NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, JUNE 3, 2021
2:00 P.M.

505 CITY PARKWAY WEST, SUITES 108-109
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Isabel Becerra, Vice Chair
Supervisor Doug Chaffee	Clayton Chau, M.D.
Clayton Corwin	Mary Giammona, M.D.
Victor Jordan	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

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

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

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

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1) **Listen to the live audio at + 1 (415) 655-0052 Access Code: 654-642-409 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/6176132050766620175 **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. CalOptima/County of Orange Vaccine Clinic and Resource Fair Events
   b. Member Health Rewards
   c. California Advancing and Innovating Medi-Cal (CalAIM)
   d. Revised State Budget for FY 2021–22
   e. Strategic Plan Update
   f. Community Alliances Forum
   g. Media Coverage

2. Chief Medical Officer Updates
   a. COVID-19 Update

3. CalOptima FY 2021–22 Marketing and Communications Plan

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

CONSENT CALENDAR
4. Minutes
   a. Approve Minutes of the May 6, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 18, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the February 25, 2021 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the Minutes of the March 11, 2021 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee; the March 11, 2021 Special Joint Meeting of the CalOptima Board of Directors Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and Whole-Child Model Family Advisory Committees; the Minutes of the April 8, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the Minutes of the April 8, 2021 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

5. Consider Authorizing and Directing Execution of an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

6. Consider Reappointment to CalOptima Board of Directors Investment Advisory Committee

7. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

8. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

9. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee

10. Consider Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

11. Consider Selecting and Contracting with Investment Managers for CalOptima's Operating, Tier One and Tier Two Investment Accounts; Authorize Allocation of these Assets Amongst the Recommended Investment Managers

12. Consider Approval of Modifications to CalOptima Medical Affairs Policies and Procedures: GG.1304, GG.1325, GG.1500 and GG.1508

13. Consider Ratification of New Finance Policy MA.3003

14. Consider Approval of Modifications to Policy GG.1900 Behavioral Health Services to Support the Administration of Behavioral Health Services for Medi-Cal Members

15. Consider Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

16. Consider the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8

17. Consider Authorizing a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

18. Consider Ratifying a Letter of Commitment in Support of the Orange County Health Care Agency Health Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 Grant Application

19. Consider Recommendations Related to Previously Approved and Prepaid Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

20. Consider Approving CalOptima Positions on Proposed Legislation

21. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2021-22

22. **Receive and File:**
    a. April 2021 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

ADMINISTRATIVE

23. Consider Approval of the Fiscal Year 2021-22 Operating Budget

24. Consider Approval of the Fiscal Year 2021-22 Capital Budget

25. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8044: Telework Program, Authorization of the Expansion of the Telework Program, Continuation of the Temporary Telework Program, and Authorization of Related Unbudgeted Expenditures

26. Consider Authorizing of Lease Renewal Agreement for the Real Property Located at 13300 Garden Grove Boulevard, Garden Grove, California

27. Election of Officers of the Board of Directors Fiscal Year 2021-22

CLINICAL OPERATIONS

28. Consider Approval of Modifications to CalOptima Policies GG.1102, GG.1301, and GG.1313

29. Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls

NETWORK OPERATION

30. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

31. Consider Authorizing Extension and Amendments of the Fee-For-Service Hospital Contracts for Medi-Cal, OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly

32. Authorize an Amendment Extending the Term of the Kaiser Foundation Health Plan, Inc. Health Maintenance Organization Health Network Contract and Current Rates, and Ratify the Delegation Agreement Related to that Contract

33. Consider Authorizing the Extension of and Other Amendments to the CalOptima Medi-Cal Full-Risk Health Maintenance Organization, Shared-Risk Group, and Physician-Hospital Consortium Health Network Contracts Except those Affiliated with Kaiser Foundation Health Plan, Inc., and Ratification of the Delegation Agreements Related to Those Contracts

PUBLIC AFFAIRS

34. Reallocating Intergovernmental Transfer (IGT) Funds and Approve Grant for Whole-Person Care Housing Navigation and Supportive Services

35. Consider Approving CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Model of Care Approach

ADVISORY COMMITTEE UPDATES

36. OneCare Connect Member Advisory Committee Update

37. Whole-Child Model Family Advisory Committee Update

38. Provider Advisory Committee Update

39. Member Advisory Committee Update

BOARD MEMBER COMMENTS

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on June 3, 2021 2:00 PM PDT at: https://attendee.gotowebinar.com/register/6176132050766620175
2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

   Note: This link should not be shared with others; it is unique to you.

   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose** one of the following **audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR--

   TO USE YOUR TELEPHONE:

   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

   United States: (415) 655-0052

   Access Code: 654-642-409

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	May 26, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — June 3, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima/County of Orange Break Vaccination Records During Two Local Events

By all measures, the CalOptima/County of Orange Vaccine Clinic and Resource Fair events on May 15 and 22 were a resounding success. In total, 2,064 individuals age 12 and older were vaccinated at the pop-up events held in the CalOptima parking lot. Further, hundreds of $25 Member Health Rewards were distributed directly to eligible members. The outstanding turnout was driven by a variety of factors, including through Othena.com, direct text messaging to members, word-of-mouth among members' friends and family, and walk-in traffic from the nearby Outlets at Orange. The previous vaccination record for a County pop-up clinic was 560 vaccines administered.

The Resource Fair component differentiated the events from other vaccine clinics and was designed to address members' social determinants of health. OC Social Services Agency (SSA) was on-site with staff and Mobile Response Vehicles to assist individuals with applying for CalFresh and Medi-Cal. Further, 2-1-1 Orange County had a booth with representatives offering community resources to support basic needs. Community Action Partnership brought the Clementine food trolley to collect signups for future food distribution and the Tom Tom diaper bank truck to provide diapers to families in need. Dozens of preventive health screenings for carotid artery, thyroid and bone density were provided to interested attendees. Finally, a kids' activity zone engaged children while parents got their shots.

CalOptima welcomed Orange County leaders and elected officials at both events. On May 15, CalOptima Board Chair and Board of Supervisors Chairman Andrew Do, CalOptima Board Member and Board of Supervisors Vice Chair Doug Chaffee, Supervisor Don Wagner and County Health Officer, Health Care Agency (HCA) Director and CalOptima Board Member Clayton Chau, M.D., Ph.D., attended. On May 22, State Sen. Tom Umberg toured the site, spoke with staff and vaccine recipients, and visited the Resource Fair booths. He also presented State Senate Certificates of Appreciation to leaders from CalOptima, HCA and SSA.

Across the two events, 110 CalOptima staff worked either a morning or afternoon shift, helping with check-in, line control, temperature check/hand sanitizing stations, post-vaccine observation and Member Health Rewards distribution among other tasks. Staff worked hard to launch these events quickly and enthusiastically served members at the building for the first time since the pandemic began. The upcoming June 5 and 12 events are focused on administering second doses, although walk-ins will be served, according to County staff.

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Member Health Rewards Funding Received, Distribution Vendor Engaged
CalOptima recently received Intergovernmental Transfer (IGT) 10 funding of $140 million from the Department of Health Care Services (DHCS), representing dates of service July 2019 through June 2020. The estimated payment to IGT funding partners is approximately $95 million, and CalOptima's remaining portion is $45 million. As approved at the January Board meeting, the majority of CalOptima's IGT 10 dollars will be used to incentivize members to get vaccinated via the COVID-19 Member Health Rewards. The program is driven by data from DHCS, and a new type of data source recently and dramatically increased the identification of vaccinated CalOptima members. The number of vaccinated members rose from 70,000 to 250,000 almost overnight. This has created a backlog for Population Health Management, which has distributed roughly 40,000 gift cards using internal staff and Board-approved temporary staff. This no longer supports the level of member response, so staff plans to engage an existing fulfillment vendor to support mass mailings of gift cards until the Member Health Rewards vendor is contracted and takes over responsibility. Staff will bring an action to your Board in August to ratify using dollars approved for this program to cover the expenses.

CalOptima Hosts California Advancing and Innovating Medi-Cal (CalAIM) Stakeholder Meeting, Launches Web Page
On May 15, CalOptima welcomed more than 300 attendees to the CalAIM stakeholder meeting. Executive Director, Public Affairs Rachel Selleck provided an overview of CalAIM while Executive Director, Clinical Operations Tracy Hitzeman discussed the populations of focus and outreach methods. A Q&A session enabled provider and community partners to ask about CalAIM implementation, and network and care management services. To provide background on CalAIM and access to the information shared at the stakeholder meeting, CalOptima launched a detailed webpage. This centralized location will offer CalAIM updates in preparation for Phase 1 implementation in January 2022. As part of the June 3 Board meeting, staff will present CalOptima's approach to CalAIM for consideration, in advance of submission to DHCS in July.

Governor Releases Revised State Budget, Increasing Spending on Health Care
On May 14, Gov. Gavin Newsom announced the Revised State Budget (May Revise) for Fiscal Year (FY) 2021–22. The May Revise expands existing health care programs managed by DHCS and continues to support funding for CalAIM, homelessness and response to COVID-19.

- *Total State Budget:* $267.8 billion ($196.7 billion General Fund (GF)). Compared with the January Proposed Budget, this is an increase in spending of nearly 18%.
- *Total Medi-Cal Budget:* $123.8 billion ($27.6 billion GF). Compared with Medi-Cal funding in the FY 2020–21 Enacted Budget, this is an increase in spending of nearly 7%.

The California State Legislature is constitutionally obligated to pass a balanced budget by June 15, which Gov. Newsom must enact by July 1. Following my report is a staff summary of the May Revise.

Strategic Plan Update Moving Forward With Feedback From Advisory Committees
Per your Board's guidance at the February 4 meeting, CalOptima staff met with the Board Advisory Committees to gather feedback on initiative development for the 2020–2022 Strategic Plan, with a particular focus on four areas: Behavioral Health, Health Equity, Social Determinants of Health and Service Delivery Model. During a series of robust facilitated discussions with committee members in March and April, draft Purpose Statements were

developed for the four areas as well as seven Strategic Initiative Categories. Committee members also made recommendations about potential initiatives for development. Staff is in the process of finalizing the Purpose Statements as well as fleshing out the initiative recommendations and assessing their feasibility. Staff will provide an update in late summer and seek Board approval and allocations, as appropriate, in the future.

Community Alliances Forum Draws Audience for COVID-19 Vaccine, Health Equity Info
On May 11, CalOptima welcomed more than 130 attendees for a virtual Community Alliances Forum that provided a COVID-19 update and vaccine information, and addressed barriers to health equity. Regina Chinsio-Kwong, D.O., Deputy Health Officer of HCA, discussed Project Independence and how the County is partnering with community organizations to support health equity. CalOptima Chief Medical Officer Emily Fonda, M.D., shared how CalOptima is improving access to vaccines for members and distributing Member Health Rewards. CalOptima Board Vice Chair Isabel Becerra, CEO of the Coalition of Orange County Community Health Centers, and Ellen Ahn, Executive Director of KCS Health Center, highlighted Orange County initiatives to address health equity in the Latino and Asian-Pacific Islander communities during the pandemic.

CalOptima Garners Media Coverage About Mental Health, Vaccination Activity
In May, CalOptima received significant positive media attention from diverse outlets. See below:

- *Verywell Mind:* Edwin Poon, Ph.D., Director, Behavioral Health Integration, participated in an online article about senior mental health and resiliency during the pandemic. He is the first expert source quoted and highlighted in the piece. Dr. Poon's comments tie well with CalOptima's strategic priority on behavioral health. Verywell's website traffic is estimated at around 16 million visits a month.
- *Tri-County Bulletin:* Executive Director, Quality & Population Health Management Marie Jeannis was interviewed for an article about CalOptima's efforts to combat vaccine hesitancy. It ran on the front page of the Tri-County Bulletin, a newspaper that serves Orange County's Black population.
- *ABC7 Eyewitness News:* On May 13, CalOptima was covered on two ABC7 evening news programs. Reporter Tony Cabrera interviewed Dr. Fonda about vaccine hesitancy and CalOptima's response. In addition, we referred Cabrera to Board Vice Chair Becerra and Families Together of Orange County, a community health center. Both were featured positively as well.

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FY 2021–22 California State Budget: Analysis of the May Revise

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- Other Medi-Cal Proposals

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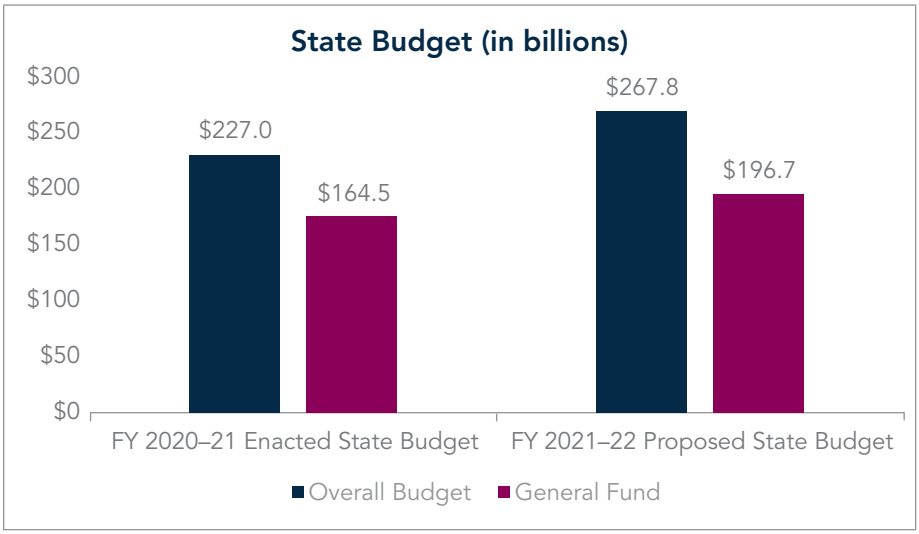
Overview

On May 14, 2021, Gov. Gavin Newsom announced the Revised State Budget (May Revise) for Fiscal Year (FY) 2021–22. After the State experienced a budget shortfall of $54 billion in 2020, the *California Comeback Plan* includes $25 billion in federal relief for an overall budget surplus of $100 billion for the next FY.

As the State continues to respond to the public health emergency, Gov. Newsom's proposed budget expands existing health care programs managed by the Department of Health Care Services (DHCS) and includes several one-time funding proposals. The May Revise proposes a total budget of $267.8 billion, including $196.7 billion General Fund (GF). In comparison with the January Proposed Budget ($227 billion, including $164.5 billion GF), this reflects an increase in spending of nearly 18%.[1] CalOptima's analysis features highlights from the May Revise, including budget provisions for California Advancing and Innovating Medi-Cal (CalAIM), homelessness and the COVID-19 pandemic.

Table 1. California State Budget



Revised State Budget

The budget increases funding for the State's Medi-Cal program to a total of $123.8 billion ($27.6 billion GF).[2] When compared with Medi-Cal funding in the FY 2020–21 Enacted Budget ($115.4 billion ($22.3 billion GF), this represents an increase of nearly 7%.The May Revise also assumes fewer Medi-Cal beneficiaries than estimated in the January Proposed Budget. The Medi-Cal caseload is expected to include approximately 14.5 million total

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Medi-Cal beneficiaries by 2022, down from 16.1 million. The total caseload is due to the suspension of Medi-Cal eligibility redeterminations, the COVID-19-driven recession and additional data on actual caseload growth.

Behavioral Health for Youth

In response to the ongoing COVID-19 pandemic, the Administration and State Legislature have prioritized behavioral health (BH) services for youth ages 25 and younger. The May Revise includes nearly $3.5 billion in proposed funding with several initiatives focusing on care coordination, prevention and access.[3] This includes implementing an incentive plan through Medi-Cal managed care plans, in partnership with county BH departments, to increase the number of students receiving preventive and early intervention BH services at school:

- $1.7 billion ($1.3 billion American Rescue Plan Act [ARPA])
- $1 billion from ARPA's Coronavirus State Fiscal Recovery Fund
- $431 million ($300 million GF) ongoing for the Children and Youth Behavioral Health Initiative
- $39.2 million GF to assist counties with serving foster youth with complex needs and BH conditions
- $30 million one-time distribution from the Mental Health Services Fund for Mental Health Student Services Act partnership grants
- $23.8 million ongoing GF to provide children aging out of Early Start provisional Lanterman service with eligibility up to age 5
- $12.4 million one-time GF for seven demonstration projects focused on advancing research and developing approaches to treating and preventing Adverse Childhood Experiences (ACEs).

CalAIM

Components of the CalAIM proposal, such as Enhanced Care Management and In Lieu of Services, continue to receive funding in the May Revise, with $1.6 billion ($673 million GF) proposed for FY 2021–22 and $1.5 billion ($746.6 million GF) for FY 2022–23. In comparison with the January Proposed Budget, this reflects an increase of $5 billion for FY 2021–22. With additional funds available, the Administration included three new proposals for CalAIM: Medi-Cal Population Health Management (PHM), Providing Access and Transforming Health (PATH), and a Medically Tailored Meals Pilot Program.[4] Of note, the preliminary PHM proposal allowed individual health plans to develop their own programs. The May Revise specifies PHM would now standardize risk stratifications and quality measures statewide, which would streamline assessments to improve care coordination through CalAIM.

Table 2. CalAIM Proposed Funding

Cost Category	May Revise Estimate
Behavioral Health	$21.8 million
Dental	$113.5 million
Enhanced Care Management	$187.5 million
Incentives	$300.0 million
In Lieu of Services	$47.9 million
Medically Tailored Meals	$9.3 million
Multipurpose Senior Services Program Carve-out	$1.6 million
Organ Transplant Carve-In	$4.7 million
PATH	$200.0 million
Population Health Management	$300.0 million
Specialty Mental Health Services Carve-Out	$-4.8 million
State Operations Funding	$38.9 million
Transitioning Populations	$401.6 million

COVID-19

The State continues to recover from the COVID-19 pandemic-driven recession and public health emergency. As of May 2021, 3.6 million California residents have contracted COVID-19, including nearly 62,000 people who have died.[5] The May Revise highlights the State's ongoing response to the pandemic using state and federal funds, including the most recent $27 billion from ARPA.

The State calculates significant fiscal impacts related to the pandemic, including $5.6 billion in total costs in FY 2020–21 and $12.1 billion in total costs in FY 2021–22. This includes costs for contact tracing, testing, vaccine administration and temporary provider reimbursements.[6]

Table 3. COVID-19 Costs to the State[7]

Cost Category	May Revise Estimate
Community Engagement	$193.3 million
Contact Tracing and Tracking	$233.1 million
Hospital and Medical Surge	$1.2 billion
Hotels for Health Care Workers	$277.9 million
Housing for the Harvest	$24.2 million
Procurements	$2.9 billion
State Response Operations	$2.3 billion
Statewide Testing	$1.8 billion
Support for Vulnerable Populations	$1.7 billion
Vaccine Distribution and Administration	$1.3 billion

Furthermore, DHCS estimates a significant offset in state spending due to increased federal funding from the Families First Coronavirus Response Act that is projected to remain through December 2021 due to the ongoing public health emergency. This specifically includes:

- $4.4 billion in additional FY 2020–21federal funding, offsetting $2.6 billion in GF costs
- $3.6 billion in additional FY 2021–22 federal funding, offsetting $2.3 billion in GF costs

Of note, upon the conclusion of the public health emergency, the May Revise includes one-time funding of $73 million ($36.5 million GF) for FY 2021–22 and FY 2022–23 to resume annual Medi-Cal redeterminations.[8]

Covered Benefits

In addition to proposing the CalAIM initiative, Gov. Newsom suggests the Medi-Cal program expand the list of covered benefits and address issues related to health equity and cultural sensitivity. In response, the May Revise includes the following two new proposals:

- Doula Care: The May Revise includes $403,000 ($152,000 GF) in FY 2021–22 and approximately $4.4 million ($1.7 million GF) annually to add doula services as a Medi-Cal covered benefit, effective January 1, 2022.[9]
- Dyadic Care: The May Revise includes $200 million ($100 million GF) annually to introduce a new statewide Medi-Cal benefit that would provide integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, increase rates of immunization completion, offer social-emotional health services, foster developmentally appropriate parenting and promote maternal mental health.[10]

Of note, Proposition 56 directed payments, In-Home Support Services (IHSS) and optional adult Medi-Cal benefits that were scheduled for suspension in 2021 are now proposed to receive ongoing funding and have been removed from the suspension list.

Homelessness

The homeless crisis continued to emerge throughout the pandemic. The State's response with Project Roomkey, and then Project Homekey, was successful at both housing those experiencing homelessness and reducing their risk of contracting COVID-19.[11] The May Revise builds off the January Proposed Budget, increasing homeless services from $2.1 billion to $6.8 billion. This includes $3.5 billion in one-time funds over two years for Project Homekey, with $1 billion specifically targeting those who are experiencing or at risk of homelessness. In total, the May Revise includes $11.9 billion over the next two FYs with a goal of ending homelessness statewide.[12]

Medi-Cal Expansion

Originally proposed in 2019 and suspended due to the pandemic, the May Revise seeks to expand Medi-Cal eligibility to those 60 years or older, regardless of immigration status. This includes $69 million ($50 million GF) in FY 2021–22 and $1 billion ($859 million GF) ongoing to expand Medi-Cal, including IHSS, to undocumented adults ages 60 and older, effective no sooner than May 1, 2022.[13]

The May Revise also includes a five-year Medi-Cal eligibility expansion program for postpartum women. This would extend eligibility for full-scope Medi-Cal from six months to 12 months postpartum. Effective no sooner than April 1, 2022, the May Revise includes $90.5 million ($45.3 million GF) in FY 2021–22 and $362.2 million ($181.1 million GF) annually between FY 2022–23 and FY 2027–28 to implement the expansion.[14]

Medi-Cal Rx

The pharmacy benefit will remain carved-in to managed care through the remainder of this calendar year. However, for budgeting purposes, the Administration anticipates the carve-out will take place no sooner than January 1, 2022. With the current placeholder in the May Revise, the Medi-Cal Rx carve-out is expected to result in ongoing annual savings of $859 million ($309 million GF). Due to the timing of various Medi-Cal Rx transition impacts, the May Revise also assumes temporary costs of $32 million ($14 million GF) in FY 2020–21 and $363 million ($134 million GF) in FY 2021–22.[15] The Administration is still discussing an implementation plan and will provide an update in the coming months.

Telehealth

As part of the Administration's proposal to extend telehealth flexibilities implemented during the pandemic, DHCS will establish audio-only telehealth rates at 65% of the Medi-Cal fee-for-service rate and a comparable alternative to prospective payment system rates for community clinics to maintain an incentive for in-person care. DHCS will consult with stakeholders to establish utilization management protocols for all telehealth services prior to implementation of post-pandemic telehealth services.[16]

Other Medi-Cal Proposals

Gov. Newsom included additional key proposals impacting Medi-Cal within the May Revise:

- Community Health Workers: $16.3 million ($6.2 million GF), increasing to $201 million ($76 million GF) by FY 2026–27, to add community health workers to the class of health workers permitted to provide services to Medi-Cal beneficiaries, effective January 1, 2022.[17]
- Health Information Exchange: $2.5 million GF for the Health and Human Services Agency to lead efforts and stakeholder engagement in building out information exchange for health and social services programs.[18]
- Master Plan for Aging Implementation: An April 1, 2021, proposal included $3.3 million GF ongoing to provide the Department of Aging with policy, project management and information technology leadership necessary to implement the Master Plan for Aging.[19]
- Regional Center Mobile Crisis Teams: $8 million GF in FY 2021–22, increasing to $11 million GF ongoing in FY 2022–23, for Systemic, Therapeutic, Assessment, Resources and Treatment (START) teams. The START teams provide 24-hour crisis prevention and response services to individuals with intellectual or developmental disabilities.[20]

Next Steps

The California State Legislature is constitutionally obligated to pass a balanced budget by June 15, 2021, which must be enacted by the Governor by July 1, 2021. Many of these proposals, such as CalAIM, require additional legislation to implement. CalOptima will continue to closely monitor ongoing budget discussions and provide updates regarding issues that impact the advancement of CalOptima's legislative priorities.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact:

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Endnotes

[1] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 13
[2] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 84
[3] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pgs. 79–80
[4] DHCS May Revise Budget Highlights, May 14, 2021, Pg. 7
[5] California COVID-19 State Dashboard, May 17, 2021
[6] DHCS May Revise Budget Highlights, May 14, 2021, Pg. 10
[7] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 30
[8] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 87
[9] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 85
[10] DHCS May Revise Budget Highlights, May 14, 2021, Pg. 5
[11] Legislative Analyst's Office: California's Homelessness Challenges in Context, January 21, 2021
[12] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 5
[13] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 82
[14] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 85
[15] DHCS May Revise Budget Highlights, May 14, 2021, Pg. 12
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A Public Agency

CalOptima

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COVID-19 Update

Board of Directors Meeting
June 3, 2021

Emily Fonda, MD, MMM
Chief Medical Officer

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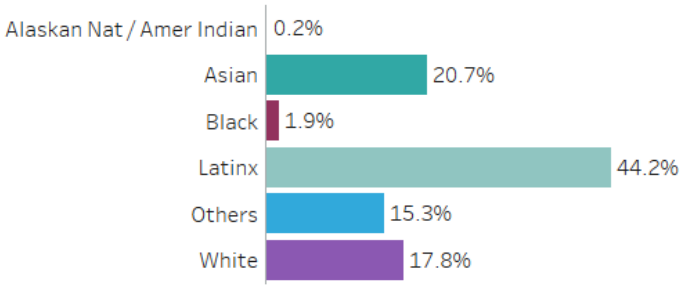
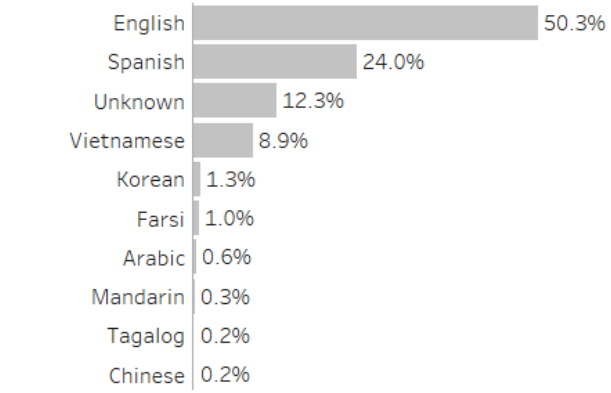
Population Analysis by COVID-19 Risk Factors (May 2021)

All Total Members	All High Risk Conditions	All LTC Residents
838,156	212,430	4,023

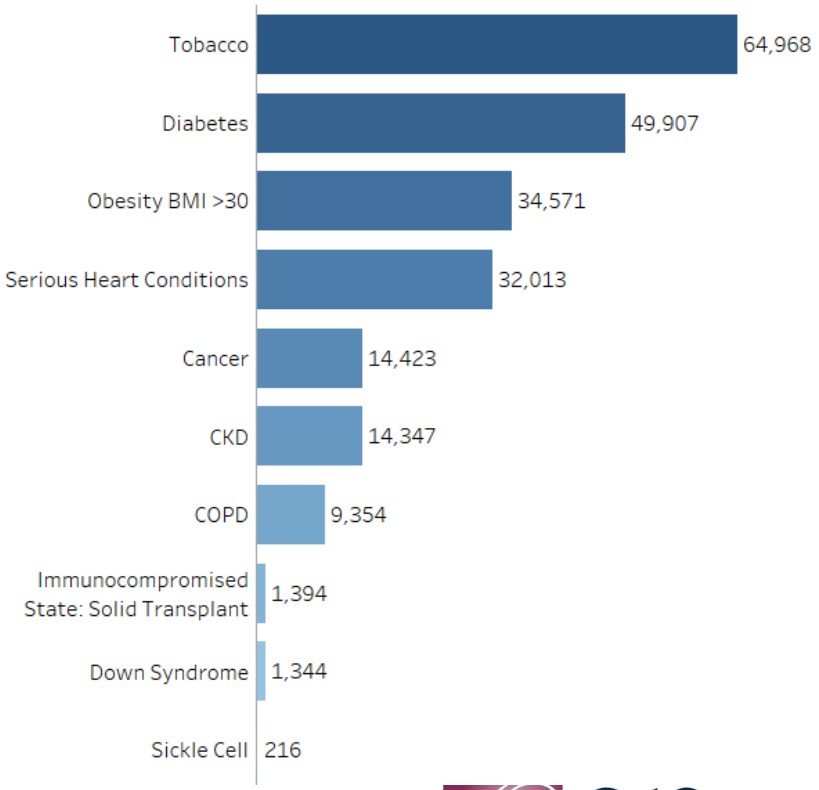
Member Counts by Ethnicity: All



Member Counts: Top Ten Languages: All



Member Counts by High Risk Conditions



Source: CalOptima Enterprise Analytics, CDC Recommended High Risk Conditions, June 2020–May 2021

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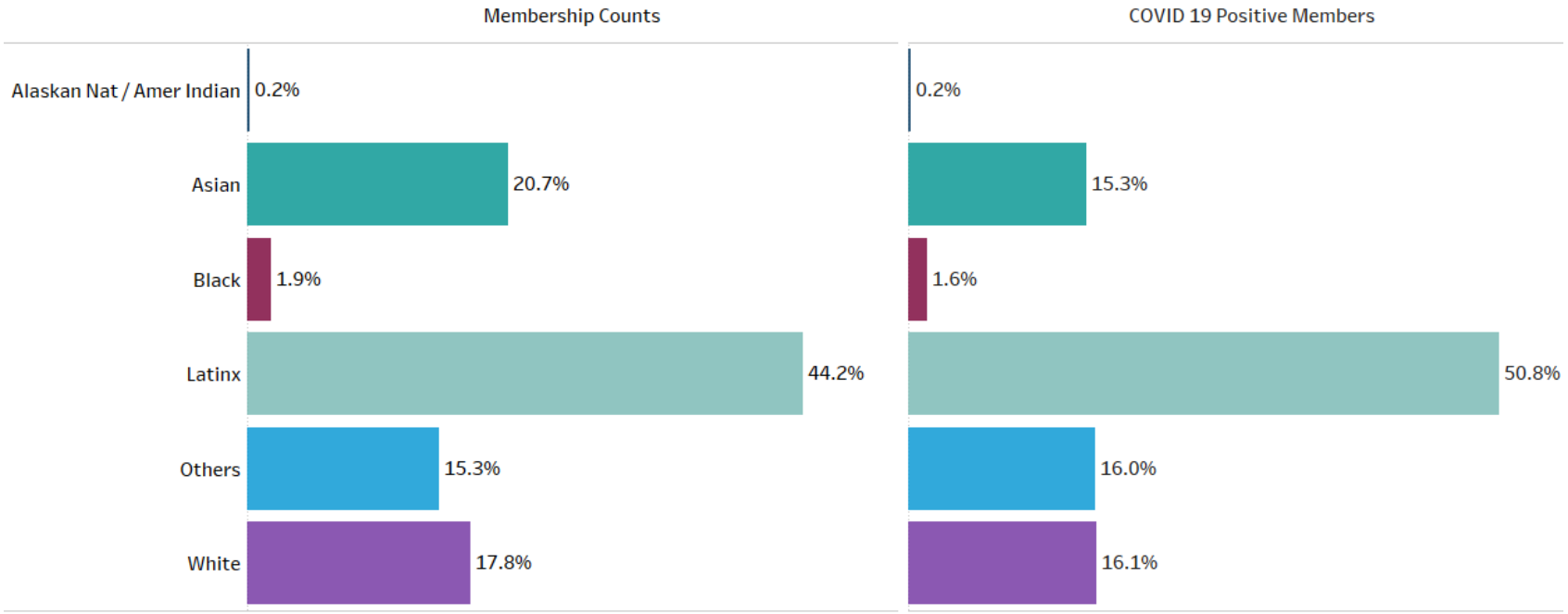
CalOptima A Public Agency

Member COVID-19 Data (May 2021)

- Latinos account for 50.8% of COVID-19 cases and make up 44.2% of CalOptima's membership
- Blacks account for 1.6% of cases and make up 1.9% of membership



Source: CalOptima Enterprise Analytics, COVID-19 cases coded using Claims and Encounters received though May 2021

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CalOptima
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CalOptima Membership, COVID-19 Cases and Vaccination Data

- As of May 21, 2021, CalOptima has approximately 838,000 members (655,661 age 12 and older)
  - 4.4% members tested positive for COVID-19 (0.1% expired)
  - 259,565 members are vaccinated
  - 239,136 members are eligible for incentives
  - 45% members 16 years and older received at least one dose of vaccine
  - 40% members 12 years and older received at least one dose vaccine
- 51,751 gift cards sent for general members (as of 5/25)

Covid Case Source: CalOptima Claims & Encounters

Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, Health Network Submissions

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CalOptima
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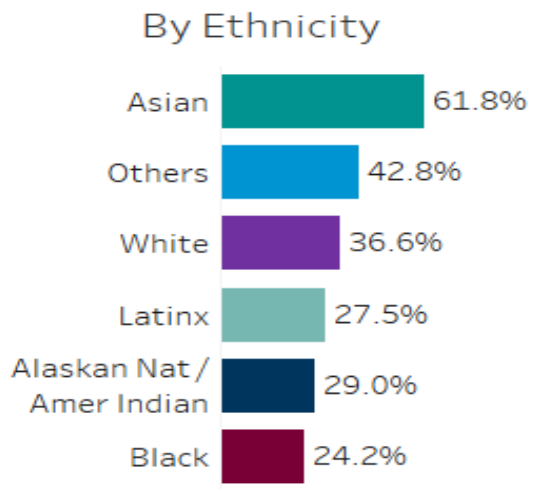
CalOptima COVID-19 Vaccination Data (May 2021)

- Highest vaccination rate: 50~55% for Westminster, Garden Grove, and Irvine
- 65 and older vaccination rate: about 70%
- LTC members vaccination rate: about 90%
- Asian population: 62% vaccinated
- Black population: 24% vaccinated

By Age Group

Age 75+	69.1%
Age 65-74	67.4%
Age 50-64	52.9%
Age 16-49	35.5%
Age 12-15	0.4%



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COVID-19 Efforts in Progress

- CalOptima's Vaccine Events
  - May 15th Event
    - 820 individuals vaccinated
    - 252 gift cards distributed
  - May 22nd Event
    - 1,244 individuals vaccinated
    - 531 gift cards distributed
  - Collaborations
    - Social Services Agency, 211 OC, Community Action Partnership OC (Tom Tom Diaper Stork and Clementine Mobile Food Trolley) and Pacific Health and Wellness (Screenings)
- Future Vaccine Events
  - June 5, 2021
  - June 12, 2021

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COVID-19 Efforts for Members Experiencing Homelessness

- 935 gift cards distributed (as of 5/26)
  - CalOptima is collaborating with the following entities to promote vaccination through health rewards:
    - Orange County Health Care Agency (OCHCA)
    - AltaMed
    - Family Together
    - Korean Community Services
    - Share Our Selves
  - Gift cards provided on-site after receiving the COVID-19 vaccine dose
  - Weekly reports sent to CalOptima from Federally Qualified Health Centers and OCHCA

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COVID-19 Outreach Efforts

- Texts sent to all members in all threshold languages
  - Arabic, Farsi, Chinese, Korean, Spanish, Vietnamese and English
- May 15th Vaccine Event
  - 259,000 text messages to age 16 and older
- May 22nd Vaccine Event
  - 198,000 text messages to age 12 and older
- Overall opt-out rate is 5.9% as of 4/22
  - Significantly lower than benchmark opt out rate at 10-15% expected for Medicaid members

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Motivation to Get Vaccinated

- It's important to get vaccinated to help protect other members of your family from becoming sick
- Getting vaccinated will allow all families and friends to be able to get back together sooner
- The pandemic can get wiped out with widespread vaccination the same way that polio was stamped out years ago with a vaccine that's still in use today
- The best way to get rid of new strains of COVID-19 is to stop the spread by getting vaccinated
- The best way to avoid the long-term effects of COVID-19 is to avoid it in the first place by being vaccinated

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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CalOptima

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FY 2021–22 Marketing and Communications Strategy

Board of Directors Meeting

June 3, 2021

Rachel Selleck, Executive Director, Public Affairs

Back to Agenda

Health Care Landscape

- CalOptima is operating in a changed environment
  - COVID-19 health and economic impacts
  - Telehealth and provider engagement
  - California Advancing and Innovating Medi-Cal initiatives
  - New competitive considerations
    - Independent Program of All-Inclusive Care for the Elderly organizations in Orange County
    - OneCare Connect to OneCare transition

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CalOptima
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Marketing and Communications Goals

- Strengthen CalOptima's brand recognition and reputation
- Raise awareness of CalOptima's programs, initiatives and services
- Promote health and wellness and quality goals
- Position CalOptima as a model public agency and community health plan

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Audiences

- Current and prospective members
- Providers
- Health networks
- Community-based organizations
- Elected officials
- Community at large
- Media

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Core Messages

- Key tenets are woven into CalOptima's marketing and communications efforts

- CalOptima:
  - Puts members first
  - Delivers access to quality health care
  - Values and respects our provider community
  - Spends public funds wisely
  - Seeks community engagement and partnerships

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Strategic Priorities and Approach

- Strategic priorities guide marketing/communications efforts
- Campaigns are developed collaboratively with input from internal leadership and external stakeholders
- Staff-driven communications tactics are combined with paid use of marketing channels
- Materials are culturally appropriate and in multiple languages

Strategic Priorities
COVID-19 Response
Program Success
Social Determinants of Health (SDOH)
Health Equity
Behavioral Health
Quality Improvement
Community Engagement

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Communications Tactics

- Established tactics
  - Website
  - Social media
  - Press releases
  - Earned media
- Newer tactics
  - Animated videos
  - Collaboration and partnerships
  - Electronic communications
    - Member texting campaign
    - 2021 Report to the Community on COVID-19 response

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CalOptima
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Marketing Tactics

- FY 2021–22 priorities reflect CalOptima's plan to expand marketing reach
  - Within all applicable regulatory requirements
- Further investment is based on health care landscape
- Channels
  - Direct mail
  - Newspapers
  - Radio
  - Television
  - Outdoor
  - Digital advertising
  - Collateral materials
  - Outreach events
  - Promotional items

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Medi-Cal

- FY 2021–22 priorities
  - Maintain commitment to CalOptima brand awareness
  - Expand campaigns to a year-round presence
  - Offer continued COVID-19 education
    - Address vaccine safety, hesitancy
    - Respond to changes as pandemic resolves
    - Promote behavioral health resources
  - Launch campaigns that support HEDIS quality performance
  - Support strategic priorities, such as SDOH and health equity

Back to Agenda

OneCare Connect/OneCare

- FY 2021–22 priorities
  - Prepare for upcoming CalAIM-driven transition, with the potential for membership decrease and increased aggressive marketing from competing Medicare Advantage plans
  - Increase advertising efforts to year-round, with emphasis during open enrollment period
  - Add television advertising
  - Increase direct mail outreach
  - Support enrollment events

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PACE

- FY 2021–22 priorities
  - Respond to competition from two independent PACE organizations in Orange County
  - Refresh the look and feel of marketing materials
  - Boost radio and television, including in multiple languages
  - Provide support for enrollment and retention events
  - Expand outdoor campaign, including new van wraps

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Next Steps

- Obtain Board approval of agency budget
- Develop and launch specific campaigns within CalOptima's lines of business

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CalOptima
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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

May 6, 2021

A Regular Meeting of the CalOptima Board of Directors was held on May 6, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:03 p.m. and Vice Chair Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair (left at 3:52 p.m.); Isabel Becerra, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan (at 3:10 p.m.); Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.
(All Board Members participated remotely except Chairman Do and Director Chau, who attended in person)

Members Absent: None.

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items in his report, including the appointment of Marie Jeannis as Executive Director, Quality and Population Health Management. She had been serving in this position in an interim capacity since February. Mr. Sanchez also reported that CalOptima released its electronic 2021 Report to the Community via email to providers, community partners, and employees. The report is also available on CalOptima's website. He also noted that CalOptima is hosting a California Advancing and Innovating Medi-Cal (CalAIM) stakeholder meeting on May 14, 2021 in preparation to launch CalAIM in January 2022.

2. Chief Medical Officer Updates

Dr. Thanh-Tam Nguyen, Medical Director, provided a COVID-19 update, noting that as of this week, over 198,000 CalOptima members had been vaccinated and of those, approximately 182,680 are eligible to receive vaccine incentives. Dr. Nguyen also noted that CalOptima has been utilizing a texting campaign to reach out to members about the importance of being vaccinated and will also be hosting pop up events at grocery stores and other locations.

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3. Introduction to the FY 2021-22 CalOptima Budget: Part 2

Nancy Huang, Chief Financial Officer, provided an overview of the FY 2021-22 CalOptima Budget – Part 2 and next steps in the budget planning process, including a presentation with additional details. Ms. Huang noted that there will be an in-depth review and discussion of the proposed budget at the May 20th Finance and Audit Committee meeting ahead of staff returning to the Board with recommendations for approval of the budget at the Board's regular June meeting.

PUBLIC COMMENTS

There were no requests for public comment.

Chairman Do noted that he was dividing the Consent Calendar into three parts due to potential conflicts of interest. The first part included Agenda Items 4, 8, and 12, which he would be presiding over. The second part included Items 6, 9, and 10, to be presided over by Vice Chair Becerra. The third part included Item 7, to be presided over by Director Giammona.

Chairman Do continued Items 5, 11, and 14 with direction to include additional detail in the staff reports. He also deleted Item 15 from the agenda due to it involving a topic being considered by the delivery system ad hoc.

For the record, Director Schoeffel did not participate in any of the Consent Calendar items due to potential conflicts of interest.

CONSENT CALENDAR

4. Minutes

a. Approve Minutes of the April 1, 2021 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of February 11, 2021 CalOptima Board of Directors' Provider Advisory Committee and the Minutes of the February 11, 2021 CalOptima Board of Directors' Member Advisory Committee

8. Consider Extension of the Professional Services Contracts for Clinics Associated with Providence St. Joseph Healthcare

Vice Chair Becerra did not participate in this item due to her affiliation with the Coalition of Orange County Community Health Centers.

12. Receive and File

a. March 2021 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved Consent Calendar Items 4, 8 and 12 as presented. (Motion carried 8-0-0 (except as noted); Directors Jordan and Schoeffel absent)***

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5. Consider Approval of Modifications to CalOptima Medical Affairs Policies and Procedures
This item was continued for further study.

6. Consider Extension of Ancillary Services Contracts
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act.

9. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts Affiliated with Providence St. Joseph Heritage Healthcare and its Affiliates
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act.

10. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts, Except Those Associated with Providence St. Joseph Heritage Healthcare and its Affiliates
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Tran did not participate in this item due to role as an Orthopedic Surgeon.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved Consent Calendar Items 6, 9 and 10 as presented. (Motion carried 6-0-1 (except as noted); Chairman Do abstained; Directors Jordan and Schoeffel absent)***

7. Consider Extension of the Professional Services Contracts for clinics, Except Those Affiliated with Providence St. Joseph Healthcare
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Vice Chair Becerra did not participate in this item due to her affiliation with the Coalition of Orange County Community Health Centers.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved Consent Calendar Item 7 as presented. (Motion carried 5-0-1; Chairman Do abstained; Vice Chair Becerra, Directors Jordan and Schoeffel absent)***

11. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Employee Handbook and Human Resources Policy; Consider Authorizing Unbudgeted Sick Leave Expenditures
This item was continued for further study.

REPORTS

13. Consider Adopting Resolutions Authorizing the Appointment of Retired Annuitants to Carry out the Duties and Responsibilities of Medical Directors During the Recruitment to Permanently Fill Vacancies and Ensure Continuity of Services and Prevent the Stoppage of Public Business

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Staff noted a correction to the recommended action and to the title of Resolution No. 21-0506-02.

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Adopted Resolution No. 21-0506-02, with the changes noted above, approving an exception of the 180-day waiting period, authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code sections 7522.56 and 21221(h), and certifying the nature of the employment of Dr. Donald Sharps; 2.) Authorized the Chief Executive Officer (CEO) to approve and appoint Dr. Donald Sharps prior to the 180-day waiting period as an interim appointment retired annuitant to the vacant position of Medical Director; 3.) Adopted Resolution No. 21-0506-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222(h) and certifying the nature of the employment of Dr. Richard Helmer; 4.) Authorized the CEO to approve and appoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Medical Director; 5.) Authorized the CEO, or his designee, to continue the current search for permanent Medical Directors; 6.) Authorized unbudgeted expenditures in an amount up to $71,654 from unspent budgeted funds in the FY2020-21 budget to support the recommended interim appointments through June 30, 2021; and 7.) Corrected the title of Resolution No. 21-0506-02 to strike the language, "To Medical Director Per" at the end of the second sentence and the beginning of the third sentence of the resolution. (Motion carried 7-0-0; Directors Jordan and Schoeffel absent)***

Rev. 5/6/2021

14. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

This item was continued for further study.

15. Consider Approval of CalOptima Policy to Establish a Process and Criteria for Health Network Contract Model Changes

The Chair directed staff to delete this item from today's agenda while the Delivery System Board Ad Hoc completes its work.

16. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend CalOptima's contract with Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2021. (Motion carried 8-0-0; Director Jordan absent)***

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17. Consider Selecting and Contracting with a Vendor for Federal Advocacy Services

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Approved recommended federal advocacy firm Potomac Partners DC to represent CalOptima for federal regulatory and legislative advocacy services; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended vendor for federal advocacy services at a monthly rate not to exceed $12,500 per month plus approved expenses for the period of May 21, 2021 through June 30, 2024, plus two one-year extension options, each exercisable at CalOptima's sole discretion; and 3.) Authorized expenditures per the terms of the proposed contract. (Motion carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

19. Member Advisory Committee Update

Christine Tolbert, Chair, Member Advisory Committee (MAC), provided an overview of the activities of the MAC including reviewing CalOptima's strategic initiatives, and reviewing a slate of candidates for expiring seats on the MAC. Ms. Tolbert also noted that members of the MAC are considering meeting monthly to better align with the CalOptima Board meetings and the Provider Advisory Committee (PAC) meetings.

20. Provider Advisory Committee Update

Junie Lazo-Pearson, Chair, Provider Advisory Committee (PAC), provided an overview of the PAC activities and reminded the Board of the open invitation to attend future PAC meetings or meetings of any of the Advisory Committees.

CLOSED SESSION

The Board adjourned to Closed Session at 3:17 pursuant to: Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION: Stanford Health Care v. CalOptima et al. SCSC Case No. 21CV375310; Government Code section 54956.9, subdivision (d)(2) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION: (One Case); Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare and OneCare Connect; and Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS, Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843, Agency Negotiators: Justin Hodgdon, David Kluth and Mai Hu, Newmark Knight Frank, Negotiating Parties: Young S. Kim and Soon Y. Kim, Under Negotiation: Price and Terms of Payment.

The Board reconvened in open session at 4:00 p.m. with no reportable action taken in the closed session. The Clerk reestablished a quorum.

ROLL CALL

Members Present: Isabel Becerra, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Trieu Tran, M.D.

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(All Board Members participated remotely except Director Chau, who attended in person)

Members Absent: Supervisor Andrew Do, Chair; Scott Schoeffel; Nancy Shivers

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Clerk of the Board

Vice Chair Becerra reported that the Board met in closed session to consider several items including CalOptima's OneCare and OneCare Connect bid submissions, and that the Board was now prepared to consider Agenda Item 18.

18. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare and OneCare Connect Bid for Calendar Year 2022 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare and OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement

.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1.) Authorized the CEO to submit the Calendar Year 2022 OneCare bid, make minor changes to the final bid as necessary to address CMS feedback, and execute the OneCare contract with CMS; 2.) Authorized the CEO to submit the OneCare Connect Plan Benefit Package, make any minor changes as necessary to address CMS feedback and execute the three way contract with CMS and DHCS; and 3.) Authorized the CEO to enter into and/or amend the OneCare and OneCare Connect Health Network contracts and take other actions as necessary for implementation. (Motion carried 6-0-0; Chairman Do, Directors Schoeffel, and Shivers absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
None.

Hearing no further business, Vice Chair Becerra adjourned the meeting at 4:04 p.m.

ADJOURNMENT

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 3, 2021

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 18, 2021

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on February 18, 2021 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Isabel Becerra called the meeting to order at 2:04 p.m. Director Corwin led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin; Scott Schoeffel (all Members at teleconference locations)

Members Absent: None

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

MANAGEMENT REPORTS
1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided three updates. The first update was on the Medi-Cal Pharmacy benefit transition. Ms. Huang noted that the Department of Health Care Services' (DHCS's) plan to implement the carve out effective April 1, 2021 has been delayed and the state has not yet identified a revised implementation date. Staff will keep the Board updated as we receive more information. The second update was regarding the Hospital Quality Assurance Fee (HQAF) program (SB 239). Ms. Huang reported that, included in CalOptima's January 2021 capitation was $209 million for the HQAF program. Staff expedited payment of these funds to qualified hospitals on February 12, 2021. The third update was on the Request for Proposal (RFP) for Investment Portfolio Manager Services. Ms. Huang reported that staff released a new RFP at the end of January. The last time that

CalOptima conducted a RFP for Investment Portfolio Manager Services was in 2015. She also noted that the evaluation team for this RFP includes CalOptima staff, representatives from Meketa, CalOptima's investment advisory firm, and members of CalOptima CalOptima's Investment Advisory Committee (IAC).

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period October 1, 2020 through December 31, 2020. As reported to the Board of Directors' Investment Advisory Committee, she noted that all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Board-approved Annual Investment Policy during that period.

CONSENT CALENDAR

3. Approve the Minutes of the November 19, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the October 19, 2020 Regular Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

4. Consider Recommending CalOptima Investment Advisory Committee Membership and Chair Reappointments

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors reappoint Patrick Moore: 1) to the Board's Investment Advisory Committee (IAC) for a two-year term effective March 7, 2021; and 2) to serve as Chair of the IAC, for a two-year term beginning March 7, 2021, or until a successor is appointed. (Motion carried 3-0-0)***

5. Consider Recommending that the Board of Directors Authorize Modifications to CalOptima Operations Policies and Procedures

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: approve modifications to the following policies and procedures: 1.) CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification and 2.) MA.4010: Health Network and Primary Care Provider Selection, Assignment and Notification. (Motion carried 3-0-0)***

6. Consider Recommending that the Board of Directors Authorize Modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Director Schoeffel did not participate in this item due to potential conflicts of interest.

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Action: ***On motion of Director Corwin, seconded and carried, the Committee recommend Board of Directors approval of modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks (Motion carried 2-0-0; Director Schoeffel absent)***

7. Consider Recommending that the Board of Directors Ratify Budget Reapportionment Changes in the CalOptima Fiscal Year 2019-20 Capital Budget for Various Information System Capital Projects

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors ratify reapportionment of budgeted funds among capital expense categories for various Information Systems capital projects. (Motion carried 2-0-0; Director Schoeffel absent)***

8. Consider Recommending Board of Directors Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: 1.) Ratify and authorize the unbudgeted expenditures in an amount up to $262,500 from existing reserves for mailing member education materials related to the Coronavirus (COVID-19) vaccination; 2.) Authorize unbudgeted expenditures in an amount up to $695,974 from existing reserves for the COVID-19 Member Vaccination Incentive Program (VIP) to include the OneCare and OneCare Connect populations, subject to regulator(s) approval, as necessary; 3.) Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $221,145 for staffing resources for the COVID-19 Member VIP; and 4.) Authorize funding for staffing resources for the COVID-19 Member VIP prior to CalOptima's receipt of IGT 10 funds from the State of California. (Motion carried 2-0-0; Director Schoeffel absent)***

9. Consider Recommending Board of Directors Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors ratify and authorize unbudgeted expenditures related to the coronavirus pandemic from existing reserves for emergency purchases in an amount not to exceed $17,925 through June 30, 2021. (Motion carried 2-0-0; Director Schoeffel absent)***

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10. Consider Recommending Board of Directors Adoption of a Resolution Approving Updates to CalOptima Policy GA. 8058: Salary Schedule and Actions Related to Recommendations from Independent Compensation Consultant Grant Thornton

It was noted that there was a correction in the summary of recommendations on page 9 of the PowerPoint. The third main bullet point and its subpoints that reference the FY2021-22 budget were included in error and should be deleted as they are not included in the recommended actions.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors: 1) Receive Report from independent consultant Grant Thornton on employee compensation and benefits benchmarking and analysis, including Appendix: Custom Peer Groups; 2.) Adopt Resolution approving updated CalOptima Policy GA.8058: Salary Schedule, with the updated Salary Schedule implemented on March 14, 2021; 3.) Authorize the Chief Executive Officer to administer CalOptima compensation practices in accordance with CalOptima policies and Grant Thornton recommendations; and 4.) Direct staff to research deferred compensation plan options and return to the Board with further recommendations. (Motion carried 3-0-0)***

11. Consider Recommending Board of Directors Adoption of Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors approve the proposed Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan. (Motion carried 3-0-0)***

INFORMATION ITEMS

12. Introduction to FY 2021-22 CalOptima Budget Primer

Ms. Huang provided an overview of the budget details for the next fiscal year.

13. Business Insurance Renewal for Policy Year 2021 Update

Kelly Klipfel, Director, Financial Compliance provided a update on the business insurance renewals for policy year 2021.

14. Request for Proposal for Investment Portfolio Manager

Ms. Huang provided an overview of the Investment Portfolio Manager Request for Proposal.

15. Risk Assessment and Internal Audit Update

Silver Ho, Executive Director, Compliance, introduced CalOptima's consultants from Grant Thornton, who provided and update on CalOptima's risk assessment results and audit plan. They provided an overview of the risk assessment methodology, noting that the purpose of the internal audit function is to perform risk assessments to identify, rank, and calibrate the risks faced by CalOptima, inclusive of evaluating existing controls and procedures. The information obtained from the risk assessment is used to develop a multi-year internal audit plan tailored to CalOptima's unique risk profile. Grant Thornton

staff provided a summary of the risk assessment results, noting that Cyber risk (Information security Cyber breach response), and Information Technology (IT) Asset Management were identified as posing high risk. Grant Thornton staff also provided an overview of the three-year Internal Audit Plan covering 2020 - 2023.

The following Information Items were accepted as presented.

16. December 2020 Financial Summary
17. CalOptima Information Security Update
18. Quarterly Operating and Capital Budget Update
19. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Health Homes Financial Report
    d. Reinsurance Report
    e. Health Network Financial Report
    f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for their work that went into preparing for the meeting.

CLOSED SESSION
The Finance and Audit Committee adjourned to closed session at 3:25 p.m. pursuant to Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATIORS Property: 13300 Garden Grove Blvd., Garden Grove, CA 92843 Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank Negotiating Parties: Young S. Kim and Soon Y. Kim Under Negotiation: Price and Terms of Payment

The Finance and Audit Committee adjourned from closed session at 3:46 p.m., with no reportable action taken.

ADJOURNMENT
With no further business, the Finance and Audit Committee meeting was adjourned at 3:47 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 20, 2021

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 25, 2021

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on February 25, 2021 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

At 3:05 p.m., Chair Mary Giammona, M.D., announced that Director Tran was running late, and that staff could provide informational updates until he arrived. Sharon Dwiers led the Pledge of Allegiance.

PUBLIC COMMENTS

There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Medical Officer Update

Emily Fonda, M.D., Interim Chief Medical Officer, reviewed the latest COVID-19 numbers, and reported a snapshot of CalOptima's population at the beginning of the year until the end of December 2020. CalOptima membership totals 806,334; first quarter of 2021 membership is at 818,000, 12,100 are experiencing homelessness of our members and 4148 are confined to long-term care facilities. In addition, close to 2001 members or more have one or more medical conditions that placed them at high risk if they contract a COVID infection. Dr. Fonda also provided information on vaccination efforts to date.

INFORMATION ITEMS

9. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

Elizabeth Lee, Director, CalOptima PACE, noted that the Program of All-Inclusive Care for the Elderly Member Advisory Committee (PMAC) report is provided in the meeting materials and asked if there were any questions. Ms. Lee also noted that most of the members of the PMAC are PACE members, and they have transitioned to virtual meetings since the pandemic.

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Committee Report
b. Program of All-Inclusive Care for the Elderly Report
c. Member Trend Report

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Chair Giammona asked that staff report both raw or absolute grievance counts and per 1,000-members when there is an increase in grievances in future reports.

CALL TO ORDER

A quorum of the Board of Directors' Quality Assurance Committee was achieved at 3:39 p.m.

Members Present: Mary Giammona, M.D., Chair; Trieu Tran, M.D. (via teleconference)

Members Absent: None

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel, Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Sharon Dwiers, Clerk of the Board

CONSENT CALENDAR

2. Approve the Minutes of the December 10, 2020 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Tran, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0)***

REPORTS

Recommended Actions for Agenda Items 3 and 4 were each read into the record and were approved in one motion and vote.

3. Receive and File 2020 CalOptima Quality Improvement Program Evaluation

Esther Okajima, Director, Quality Improvement presented a review of the 2020 Quality Improvement (QI) Program evaluation accomplishments, including: CalOptima receiving recognition by the Department of Health Care Services (DHCS) as the highest performing Medicaid plan in California; CalOptima meeting all DHCS Managed Care Accountability Set (MCAS) measures required to achieve Minimum Performance Level (MPL) in measurement year (MY) 2019; CalOptima completing successful incentive outreach to members in MY 2019 to obtain preventive care, which resulted in improvements for HEDIS, including well-child visits, postpartum care, breast and cervical cancer screening; and CalOptima demonstrating the highest Adverse Childhood Experiences (ACE) screening rate among Managed Care Plans (MCPs). In addition, CalOptima recognized and rewarded outstanding performance of Health Networks and CalOptima Community Network through the comprehensive Board-approved Pay for Value (P4V) performance measurement program; CalOptima extended its Homeless Health Initiative, which included Clinical Field Team (CFT) and Community Health Center (CHC) efforts; CalOptima also implemented a Post-acute Infection Prevention Quality Initiative (PIPQI), as well as participated in the Orange County Nursing Home Infection Program, both of which reduce the spread of COVID-19 and other bacterial, fungal and viral infections; and CalOptima responded to the COVID-19 pandemic. Ms. Okajima also highlighted opportunities for improvement that were identified as part of the 2020 Quality Program and made the following recommendations: develop a comprehensive COVID-19 mitigation strategy;

continue member health rewards incentive programs specifically for preventive screenings; and expand member incentives to promote COVID-19 vaccine acceptance.

4. Consider Recommending Board of Directors Approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Ms. Okajima provided an overview of the proposed 2021 Quality Improvement (QI) Program and 2021 Quality Improvement Work Plan. She noted that much of the 2021 QI Program is based on the 2020 QI Plan Evaluation and that many of the goals for 2021 revolve around COVID-19. These include: aiming for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during the pandemic; improve members' ability to access primary and specialty care for routine appointments and achieve Accredited rating from the National Committee of Quality Assurance (NCQA) and maintain a NCQA overall rating of 4.0.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan. (Motion carried 2-0-0)***

The recommended Actions for Agenda Items 5 and 6 were approved in a single motion and vote.

5. Receive and File 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation

Miles Masatsugu, M.D., Medical Director, presented a review of the 2020 Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation accomplishments during 2020 which included the following: swiftly responding to the COVID-19 pandemic by implementing "PACE without Walls", redesigning the triage and clinical workflow to respond to the pandemic, 98% pneumococcal immunization rate, and 83% influenza immunization.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Receive and File the 2020 Program of All-Inclusive Care for the Elderly Quality Improvement Plan Annual Evaluation. (Motion carried 2-0)***

6. Consider Recommending Board of Directors Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Dr. Masatsugu provided an overview of the proposed 2021 CalOptima PACE Quality Improvement Plan, which includes the following goals: improve quality of care for participants, ensure the safety of clinical care, ensure appropriate access and availability, ensure appropriate use of resources, improve participant experience, and additional focus on COVID-19.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan. (Motion carried 2-0)***

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7. Consider Recommending Board of Directors Approval of the 2020 CalOptima Utilization Management Program Evaluation and the 2021 CalOptima Utilization Management Program Description

Tracy Hitzeman, Executive Director, Clinical Operations, reviewed the 2020 CalOptima Utilization Management (UM) Program Evaluation accomplishments including: adding a Custom DME Specialist – Physical Therapist who provides in-home assessments for members needing custom DME; and Monitoring nurses to ensure compliance with internal monitoring activities and identification of opportunities for improvement. In addition, CalOptima implemented auto authorization rules for select initial specialty consults, developed enhanced tools and templates to standardize review processes and reinforce UM principles, and enhanced over and underutilization monitoring as corporate-wide initiative. Ms. Hitzeman also provided an overview of the proposed 2021 Utilization Management Program Description. Updates to the program are based on results from the prior year's evaluation and include a COVID-19 focus.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the 2020 Utilization Management Program Evaluation and the 2021 Utilization Management Program Description. (Motion carried 2-0)***

8. Consider Recommending Board of Directors Approval of Modifications to Quality Improvement Policies

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors approve modifications to the following CalOptima policies pursuant to CalOptima's annual review process: GG.1603: Medical Records Maintenance; GG.1611: Potential Quality Issue Review Process; GG.1615: Corrective Action Plan for Practitioners; and GG.1658: Suspend, Restrict or Terminate Practitioner Participation in CalOptima's Network. (Motion carried 2-0)***

COMMITTEE MEMBER COMMENTS

The Committee members thanked staff for their work.

ADJOURNMENT

Hearing no further business, Chair Giammona adjourned the meeting at 4:49 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 19, 2021

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MINUTES

SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

March 11, 2021

A Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on March 11, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 8:00 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair; Meredith Chillemi; Gio Corzo; Josefina Diaz; Sandra Finestone; Eleni Hailemariam, M.D. (non-voting); Sara Lee;

Members Absent: Mario Parada; Donald Stukes

Others Present: Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Tasha Millspaugh, Information Services Coordinator

MINUTES

Approve the Minutes of the October 22, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Meredith Chillemi, seconded and carried, the Committee approved the minutes of the October 22, 2020 meeting by a roll call vote. (Motion carried 7-0-0; Voting Members Parada and Stukes absent)***

Approve the Minutes of the December 10, 2020 Special Joint Meeting of the CalOptima Board of Directors' Board Advisory Committees

Action: ***On motion of Member Gio Corzo, seconded and carried, the Committee approved the minutes of the December 10, 2020 meeting by a roll call vote. (Motion carried 7-0-0; Voting Members Parada and Stukes absent)***

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PUBLIC COMMENT

There were no requests for public comment

INFORMATION ITEMS

OCC MAC Member Updates

Chair Mouton notified the Committee that the annual recruitment would begin on March 15, 2021 and noted that the Representing Members with Disabilities, Representing Members of Ethnic and Cultural Community, In-Home Supportive Services Representative and Member or Family Member Representatives (2 seats) would be scheduled for recruitment as the term for these seats would expire on June 30, 2021. She reminded the members that they must reapply to be considered for reappointment if their seat was up for recruitment.

ADJOURNMENT

Chair Mouton reminded the members that there was a special joint meeting immediately following this meeting and that the next regular OCC MAC meeting is scheduled for April 22, 2021 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 8:10 a.m.

/s/Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: April 22, 2021

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MINUTES

SPECIAL JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE, PROVIDER ADVISORY COMMITTEE AND WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

March 11, 2021

A Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and Whole-Child Model Advisory Committee (WCM FAC) was held on Thursday, March 11, 2021 via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

OCC MAC Chair Patty Mouton called the meeting to order at 9:05 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Christine Tolbert, Chair; Maura Byron; Sandy Finestone; Connie Gonzalez; Jacqueline Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Melisa Nicholson; Kate Polezhaev; Sr. Mary Terese Sweeney; Steve Thronson; Mallory Vega

Members Absent: Linda Adair; Pamela Pimentel, Vice Chair

OneCare Connect Member Advisory Committee

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair; Gio Corzo; Josefina Diaz; Sandy Finestone; Sara Lee;

Members Absent: Meredith Chillemi; Eleni Hailemariam, M.D. (non-voting); Mario Parada; Donald Stukes

Provider Advisory Committee

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Alpesh Amin, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D., Tina Bloomer, WHNP; Donald Bruhns, Andrew Inglis, M.D.; Jena Jensen; Teri Miranti; Alex Rossel; Loc Tran, Pharm.D.; Christy Ward

Members Absent: John Kelly, M.D.; Peter Korchin

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Whole-Child Model Family Advisory Committee

Members Present: Brenda Deeley, Vice Chair; Maura Byron; Sandra Cortez-Schultz; Monica Maier; Malissa Watson

Members Absent: Kristen Rogers, Chair; Cathleen Collins; Jacque Knudsen; Kathleen Lear; *WCM FAC did not achieve a quorum.*

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Rachel Selleck, Executive Director, Public Affairs; Thanh-Tam Nguyen, M.D., Medical Director, Medical Management; Albert Cardenas, Director, Customer Service; Debra Kegel, Director, Strategic Development; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Customer Service

PUBLIC COMMENT

There were no requests for public comment.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Chief Executive Officer, welcomed the members of the Board Advisory Committees and updated the members on the current status of COVID-19 and the vaccination efforts that were on-going. He noted that the Third Party Administrator (TPA) for the COVID vaccines had changed to Blue Shield for the State of California. Mr. Sanchez also briefly discussed the CalAIM submission that CalOptima plans to submit by July 2021.

Chief Medical Officer Update

Emily Fonda, M.D., Interim Chief Medical Officer, updated the committees on the current COVID-19 pandemic and discussed the vaccine incentives roll-out, with an emphasis on the homeless population in Orange County.

INFORMATION ITEMS

Facilitated Discussion Regarding Strategic Plan Implementation

Rachel Selleck, Executive Director, Public Affairs and Debra Kegel, Director, Strategic Development discussed CalOptima's Strategic Plan update and the directive from the Board to

the Committees. Ms. Selleck introduced Athena Chapman and Caroline Davis of Chapman Consulting who facilitated a session with all of the committee members in attendance on four initiatives: Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health. Committee members participated in a questions and answer dialogue on all four initiatives. Both MAC and PAC will again review these initiatives at their respective April 8, 2021 meetings.

Orange County COVID Response to Older Adult Infections

Helene Calvet, M.D., Deputy Medical Director, Orange County Health Care Agency (OCHCA) and Patty Mouton, Vice President, Alzheimer's Orange County presented on how the OCHCA and Alzheimer's Orange County worked together to open a COVID care unit at the Fairview Developmental Center in Costa Mesa. Teaming together they were able to treat seniors with Alzheimer's and other related dementia who tested positive for COVID-19.

CalAIM Update

Pallavi Patel, Director, Process Excellence presented on the current status of CalAIM. Ms. Patel noted that the CalAIM pilot will begin on January 1, 2022 and will span a five year period through 2027. She noted that CalAIM's main goal was to improve member and provider experience, move Medi-Cal to a more consistent and seamless system and improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation. CalAIM will also expand the Enhanced Care Management (ECM) benefit which intensifies care management and builds on the current Whole Person Care (WPC) pilot and the Health Homes Program (HHP) for high-need Medi-Cal beneficiaries.

Federal and State Legislative Update

Jackie Mark, Sr. Policy Advisory, Government Affairs provided an update on legislative items that were of interest to the committees. She referred the members to the handout in their materials that gave more in-depth information.

COMMITTEE MEMBER UPDATES

OCC MAC Chair Patty Mouton on behalf of the MAC Chair welcomed Linda Adair to the MAC as the new Medi-Cal Beneficiaries Representative and announced that the next regular MAC meeting was scheduled for April 8, 2021 at 2:30 PM. Chair Mouton also reminded everyone that committee recruitment would begin on March 15, 2021.

Chair Mouton also reminded the OCC MAC members that their next meeting was scheduled for April 22, 2021 at 3:00 PM. She also reminded the members about the committee's recruitment also opened on March 15, 2021.

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PAC Chair Dr. Junie Lazo-Pearson announced that the next PAC meeting was scheduled for April 8, 2021 at 8:00 AM. She also told the PAC that she would be reaching out to the members about presenting at upcoming PAC meetings and also reminded the PAC members about the upcoming recruitment.

Chair Patty Mouton on behalf of WCM FAC Chair announced that the next WCM FAC meeting would be held on April 27, 2021 at 9:30 AM. She also reminded the members about the upcoming recruitment and asked the members to assist with the recruitment of Authorized Family Member Representatives.

ADJOURNMENT

There being no further business before the Committees, OCC MAC Chair Mouton adjourned the meeting at 11:35 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved by PAC: April 8, 2021
Approved by MAC: April 8, 2021
Approved by OCC MAC: April 22, 2021

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' PROVIDER ADVISORY COMMITTEE

April 8, 2021

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on April 8, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

PAC Chair Dr. Junie Lazo-Pearson, called the meeting to order at 8:02 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D; Tina Bloomer, MHNP (8:05 am); Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; Teri Miranti; Loc Tran, PharmD.; Christy Ward

Members Absent: John Kelly, M.D.; Peter Korchin; Alexander Rossel

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Chief Medical Officer; Michelle Laughlin, Executive Director, Network Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Rachel Selleck, Executive Director, Public Affairs; Claudia Magee, Manager, Strategic Development; Bárbara Kidder García, Program/Policy Analyst, Sr., Strategic Development; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service

MINUTES

Approve the Minutes of the February 11, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee.

Action: ***On motion of Member Christy Ward, seconded and carried, the Committee approved the minutes of the February 11, 2021 regular meeting. (Motion carried 12-0-0; Members Kelly, Korchin and Rossel absent)***

Back to Agenda

Approve the Minutes of the March 11, 2021 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee.

Action: ***On motion of Member Dr. Alpesh Amin, seconded and carried, the Committee approved the minutes of the March 11, 2021 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and the Whole-Child Model Family Advisory Committee. (Motion carried 12-0-0; Members Dr. Kelly, Korchin and Rossel absent)***

PUBLIC COMMENTS

There were no public comments.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, announced that Emily Fonda, M.D. had been named CalOptima's Chief Medical Officer. Mr. Sanchez also provided an update on COVID vaccines and noted that Blue Shield was now acting as the state's third party administrator for vaccine distribution. He also noted that CalOptima was continuing to work closely with the County on vaccine distribution.

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, provided an update on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. Ms. Khamseh noted that the policy included draft language that is intended to define the criteria and provides the process for CalOptima's health networks to submit requests for contract model changes. She also noted that staff was preparing to submit this policy for board consideration at the May 6, 2021 Board of Director's meeting.

Chief Financial Officer Report

Nancy Huang, Chief Financial Officer (CFO), presented a financial update to the PAC and reviewed the enrollment projection by all lines of business and also discussed the anticipated Medi-Cal revenue impact to the FY 2021-2022 CalOptima budget. Ms. Huang also reviewed budget timelines with the committee and budget considerations that included fee-for-service reimbursements and health network capitations.

INFORMATION ITEMS

COVID–19 Update

Dr. Fonda provided an update on CalOptima's COVID-19 Vaccine and Member Outreach Strategy and CalOptima's outreach efforts to approximately 806,000 CalOptima members. She noted that over 9,350 gift cards had been sent to members as an incentive for getting vaccinated. She also discussed the vaccine initiatives for members experiencing homelessness and referenced a number of myths circulating about the vaccines.

Back to Agenda

CalOptima 2020-2022 Strategic Plan Discussion

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback received from the advisory committee's joint meeting on March 11, 2021. They discussed the feedback that had been received from the advisory committees on Health Equity, Social Determinants of Health, Service Delivery Model, Behavioral Health and other categories to solicit further feedback from the PAC on the FY 2020-2022 Strategic Plan update prior to finalizing their report for the Board.

Federal and State Legislative Update

Rachel Selleck also provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including the CalOptima's Legislative Platform and Legislative Priorities brochure.

Share Our Selves (SOS): Continuing A Legacy of Providing Comprehensive Safety Net Services

Christy Ward, Chief Executive Officer of Share Our Selves (SOS), presented on how SOS is helping the Orange County community during COVID-19 and how SOS is assisting in the vaccination effort of Orange County's homeless population.

PAC Member Updates

Chair Lazo-Pearson noted that PAC's annual recruitment for seats that expire on June 30, 2021 would conclude on April 15, 2021 for the following seats: Allied Health Services Representative, Behavioral/Mental Health Representative, Health Network Representative and Nurse Representative. Chair Lazo-Pearson requested that an ad hoc be formed to assist Vice Chair Nishimoto in reviewing the incoming PAC applications for the expiring seats. Teri Miranti and Christi Ward agreed to serve on this ad hoc. She also noted that the next meeting would be May 13, 2021where the PAC would be approving their FY 2021-2022 meeting schedule and would consider a recommendation from the nominations ad hoc on PAC's slate of candidates.

ADJOURNMENT

Hearing no further business, Chair Lazo-Pearson adjourned the meeting at 9:45 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: May 13, 2021

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MINUTES

SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE

April 8, 2021

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on April 8, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Tolbert called the meeting to order at 2:33 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Maura Byron; Sandra Finestone; Connie Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Melisa Nicholson; Kate Polezhaev; Sr. Mary Therese Sweeney; Steve Thronson; Mallory Vega

Members Absent: Linda Adair; Jacqueline Gonzalez

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Rachel Selleck, Executive Director, Public Affairs; Albert Cardenas, Director, Customer Service; Claudia Magee, Manager, Strategic Development; Barbara Kidder Garcia, Program/Policy Analyst, Sr., Strategic Development; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service.

MINUTES

Approve the Minutes of the February 11, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Molnar, seconded and carried, the MAC approved the minutes as submitted. (13-0-0, Members Adair and J. Gonzalez absent)***

Approve the Minutes of the March 11, 2021 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Byron, seconded and carried, the MAC approved the minutes as submitted. (13-0-0, Members Adair and J. Gonzalez absent)***

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PUBLIC COMMENT

There were no public comments.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer updated the MAC members on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. Ms. Khamseh noted that the policy included draft language that is intended to define the criteria and provided the process for health networks to submit requests for contract model changes. She also noted that staff plans to prepare and submit this policy for board consideration at the May 2021 Board meeting.

INFORMATION ITEMS

MAC Member Updates

Chair Tolbert announced that MAC will hold a special meeting on May 13, 2021to approve a recommendation for the MAC slate of candidates from the current MAC recruitment that would be ending on April 15, 2021 asked for two members to assist her in reviewing and scoring applicants for seats that expire on June 30, 2021. Members Sally Molnar and Patty Mouton agreed to participate on the ad hoc committee. Chair Tolbert also directed staff to draft up a second meeting schedule that would have MAC meet monthly with the exception of January and July.

COVID-19 Update

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update and discussed the on-going vaccine efforts that were currently in progress. Dr. Fonda noted that over 9,350 gift cards had been distributed to CalOptima members as an incentive for getting their vaccine. Dr. Fonda also discussed the vaccine initiatives for those members who are homeless and addressed the myths that were circulating about the vaccines.

CalOptima 2020-2022 Strategic Plan Discussion

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback on the topic of the FY 2020-2022 Strategic Plan update received from the March 11, 2021 joint meeting of the advisory committees and the direction to solicit additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories feedback from the MAC prior to finalizing the report.

Chair Tolbert at this time rearranged the agenda to hear VI.E Federal and State Legislative Update before continuing to the Family Support Network presentation.

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Federal & State Legislative Update

Rachel Selleck also provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including the CalOptima's Legislative Platform and Legislative Priorities.

Family Support Network

Maura Byron, Executive Director, Family Support Network and current MAC member presented on how the Family Support Network offered resources and advocacy for families and children with social, emotional, intellectual and physical needs so they could achieve their full potential by offering programs to empower families to be the best versions of themselves.

ADJOURNMENT

Hearing no further business, Chair Tolbert adjourned the meeting at 4:30 p.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: May 13, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Authorizing and Directing Execution of an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
TC Roady, Interim Executive Director of Compliance, (714) 796-6122

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Chairman) to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operation of the OneCare program.

Background

As a County Organized Health System (COHS), CalOptima contracts with the DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year Primary Agreement with the DHCS. Amendments to the Primary Agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary Agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman has executed four amendments to the agreement pursuant to Board authority. Agreement 16-93274 is set to terminate on December 31, 2021. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

On April 1, 2021, DHCS provided managed care plans (MCPs), including CalOptima, with a draft amendment to extend Agreement 16-93274 through December 31, 2023.

The Centers for Medicare & Medicaid Services (CMS) requires that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2022 contract year no later than July 1, 2021. Executing Amendment 05 (A-05) to Agreement 16-93274 is required in order

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for CalOptima to meet CMS's filing requirements, and to continue to operate CalOptima's D-SNP (OneCare) in contract year 2022. CalOptima has requested that DHCS send the final amendment to CalOptima as soon as possible in order to allow for immediate signature by CalOptima and prompt return to DHCS for counter-signature.

The amendment contains language changes in addition to the extension of the expiration date. DHCS has only shared boilerplate contract amendments with CalOptima at this time. If the final contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

What follows is a description of the changes contained within Agreement 16-93274.

Section/Provision:	**Updates to Provision:**
Exhibit A - SCOPE OF WORK	
1. Care Coordination	• Clarifies care coordination procedures language.
2. All Plan and Policy Letters	• Clarifies that when there are inconsistencies in DHCS Medi-Cal Program All Plan and Policies Letter with Medicare requirements, Medicare takes precedence.
3. Coverage Area and Eligible Beneficiaries	• Updates language to further clarify that dual eligible beneficiaries with a share of cost who reside in long term care facilities and are continuously certified are eligible for coverage under the D-SNP.
5. Member Billing Prohibitions	• Adds language to strengthen balance billing protections for members and plan's delegates.
7. Medi-Cal and Medicare Eligibility Verification	• Deletes the D-SNP's responsibility to confirm all applicable Medicare Advantage *special needs criteria* are met, based on D-SNP type. • Adds requirement to ensure appropriate training of Plan staff to use Medi-Cal eligibility verification systems.
8. Contract Term	• Extends the contract term through December 31, 2023.
11. CMS Documentation	• Updates the type of CMS documentation that is required to be submitted to DHCS to include the D-SNP's Model of Care and a list of approved Supplemental Benefits.
Exhibit D(F) SPECIAL TERMS AND CONDITIONS	
9. Federal Contract Funds	• Removes outdated Federal Contract Funds language.
Exhibit E, Attachment 2 PROGRAM TERMS AND CONDITIONS	
1. Governing Law	• Removes outdated Balanced Budget Act language.
9. Prohibition Against Subcontracts	• Removes Prohibition Against Subcontracts language.
27. Untitled Section	• Updates the Discrimination grievance processing requirement references.

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Fiscal Impact
The recommended action to execute Amendment 05 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 05 (A-05) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare program during 2022 and 2023.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. 2022 Draft Amendment to Agreement 16-93274

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 5

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

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

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

Exhibit A
SCOPE OF WORK

CCI Non-Cal MediConnect D-SNPs

1. Service Overview

This contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP).

D-SNP Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

Care coordination of the Medi-Cal benefits and services provided to eligible Medi-Cal beneficiaries but which are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division (MCOD) Attn: Chief, Managed Care Systems and Support Services Branch	California Attn:, President
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Contracting Officer	California Attn: President
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

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Exhibit A
SCOPE OF WORK

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed

Exhibit A
SCOPE OF WORK

1. Care Coordination

This D-SNP Contract is a care coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. **The D-SNP shall coordinate Medi-Cal benefits with Medi-Cal payers responsible for specialized Medi-Cal benefit provision to enrollees, including services listed below. Coordination of these benefits shall occur when necessary and appropriate.** D-SNP Contractor is responsible for coordinating the Member's Medicare and Medi-Cal benefits including, but not limited to, discharge planning, disease management, and care management. **Coordination of Medicaid benefits is not the enrollee's responsibility.** D-SNP Contractor shall:

A. Develop and implement care coordination procedures that are submitted to and approved by DHCS for referral and coordination of care for Members who receive benefits and services through either the Medi-Cal managed care or FFS programs. Medi-Cal benefits and services requiring referral and coordination of care by D-SNP Contractor are outlined in Exhibit H.

   1) For Medi-Cal managed care Members, Contractor's D-SNP will contact the Member's Medi-Cal managed care plan for provider information and for the coordination of Medi-Cal managed care covered benefits. Managed care health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx;

   2) For Medi-Cal FFS Members, Contractor's D-SNP will contact Medi-Cal for provider information and the coordination of Medi-Cal FFS benefits. Medi-Cal contact information can be found at the following link: http://www.medi-cal.ca.gov/contact.asp;

   3) For coordination of behavioral health services, Contractor's D-SNP will contact the Member's Medi-Cal managed care health plan and/or the county mental health plans for provider information and the coordination of behavioral health services. County mental health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx;

   4) For coordination of In-Home Supportive Services (IHSS) benefits, Contractor's D-SNP will contact the County IHSS Office. County IHSS Office contact information can be found at https://www.cdss.ca.gov/inforesources/county-ihss-offices; and

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5) For coordination of Medi-Cal Dental benefits, Contractor's D-SNP will contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits. ASO contact information can be found at the following link: http://www.denti-cal.ca.gov/WSI/contact.jsp?fname=ContactInfo.

B. Make a referral to DHCS for follow-up and possible provision of Medi-Cal benefits or services, when a Member requests or D-SNP Contractor determines a Member may need a Medi-Cal benefit or service that is not covered by D-SNP Contractor.

C. D-SNP Contractor is not responsible for the provision of, or paying reimbursement for, any Medi-Cal benefits. D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the ~~California Department of Health Care Services (~~DHCS~~)~~ website. D-SNP Contractor shall timely coordinate Medi-Cal benefits and services requiring referral and coordination of care as outlined in Exhibit H for its Enrolled Dual Eligible Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Covered Services are described in Title XIX of the Social Security Act, 42 CFR sections 440 and 441, the California Medicaid State Plan, Section 3.2, Provision 1 of this Attachment, the DHCS and Medi-Cal websites, and other relevant materials.

D. D-SNP Contractor will provide a report via SFTP in Excel format to DHCS on a monthly basis by the close of business on the sixth business day after the end of the reporting month. The report will contain all Dual Eligible Member admissions to a hospital or Skilled Nursing Facility (SNF) for any reason. Reports will include:

1) Beneficiary Demographic Information

a) First Name, Last Name

b) Medicare Beneficiary Identifier (MBI)

c) Date of Birth

d) Client Index Number (CIN) – if available

2) Inpatient Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

3) Skilled Nursing Facility (SNF) Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

4) Discharge Planning Documents (if available)

a) Discharge date and time

b) Discharge disposition

c) Discharging Facility

d) Discharge diagnosis

e) Discharge instructions

E. D-SNP Contractor will provide a summary report via SFTP to DHCS on a semi-annually basis, due July 31 and January 31 for the previous six-month period, to DHCS for Dual Eligible Members hospitalized or in a skilled nursing facility. D-SNP Contractor's report shall include the following:

Exhibit A
SCOPE OF WORK

1) Number and percentage of population hospitalized;

2) Percentage of population having care coordination prior to hospitalization;

3) Number and percentage of populations offered care coordination following hospitalization;

4) Number and percentage of population accepting care coordination;

5) Number and percentage of populations readmitted from the prior year;

6) Average length of stay;

7) Number discharged from hospital to community;

8) Number discharged from hospital to SNF;

9) Number discharged from hospital to other Facility:

10) Number discharged from SNF to community;

11) Number discharged from SNF to other Facility:

In the event that D-SNP Contractor authorizes another entity or entities to perform this notification, D-SNP Contractor must retain responsibility for complying with this requirement.

2. All Plan and Policy Letters

In addition to the terms and conditions of this Contract. D-SNP Contractor shall comply with All Plan Letters (APLs) and Policy Letters (PLs), including but not limited to APL 12-001 and 13-003, as well as any subsequent APLs, PLs, or updates, departmental updates regarding D-SNP policies for the duration of the Duals Demonstration Project in connection with Coordinated Care Initiative (CCI) counties, all of which are incorporated by reference into this D-SNP Contract.

In the event that an APL conflicts with Medicare requirements or regulations, the Medicare requirements and regulations take precedence.

3. Coverage Area and Eligible Beneficiaries

A. Contractor's D-SNP in the following CCI county may enroll the Dual

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Exhibit A
SCOPE OF WORK

Eligible Beneficiaries identified in Paragraphs B and C, subject to the eligibility limitations applicable to the CCI county:

Los Angeles County

B. In CCI counties, beneficiaries eligible for coverage under this D-SNP Contract shall be limited to the following:

1) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP or who are enrolled in the Contractor's D-SNP as of December 31, 2014;

2) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP or who are excluded from enrollment into Cal MediConnect as follows:

a) Individuals under the age of 21;

b) Individuals with other private or public health insurance;

c) Developmentally Disabled (DD) beneficiaries receiving services through a Department of Developmental Services 1915(c) waiver, regional center, or state developmental center;

d) Individuals with a share of cost ~~- in community and not~~ **who reside in a long term care facility and are** continuously certified;

e) Individuals residing in one of the Veterans' Homes of California;

f) Individuals residing in an excluded zip code per the Memorandum of Understanding (MOU) between the State and the Centers for Medicare and Medicaid Services (CMS); and

g) Beneficiaries in the following 1915(c) waiver:

i. Nursing Facility/Acute Hospital Waiver;

ii. HIV/AIDS Waiver;

iii. Assisted Living Waiver; and

iv. In-Home Operations Waiver.

h) Intermediate Care Facility - DD Residents.

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3) Dual Eligible Beneficiaries who were Members in Contractor's D-SNP as of December 31, 2014, who enroll in Cal MediConnect after December 31, 2014 and choose to disenroll from Cal MediConnect, may return to Contractor's D-SNP.

4) A Member enrolled in Contractor's D-SNP in a non-CCI county, regardless of enrollment date, who moves during the duration of the CCI Demonstration to a CCI county also covered by Contractor's D-SNP, may remain enrolled in Contractor's D-SNP.

C. In non-CCI counties, all Dual Eligible Beneficiaries eligible for enrollment in a Full Benefit D-SNP may enroll in Contractor's D-SNP.

4. Certification and Enrollment Reporting

A. D-SNP Contractor shall submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in Contractor's D-SNP as of January 1, 2017.

B. By the fifth working day of each month during the term of the D-SNP Contract, D-SNP Contractor shall submit a report, signed by the Chief Operations Officer or similar executive officer, to DHCS summarizing the previous month's Enrollment numbers.

5. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor shall not bill a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act.

B. **Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.** A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal

managed care plan as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal.

6. Provider Network Reporting Requirements

Upon execution of this D-SNP Contract, D-SNP Contractor shall submit to DHCS an initial report that outlines D-SNP Contractor's full Medi-Cal provider network within the defined Service Area.

A. D-SNP contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Any D-SNPs affiliated with a companion Medi-Cal managed care plan can obtain the file from the affiliated Medi-Cal plan.

B. Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network).

C. The report, at a minimum, shall include the following:

1) NPI (National Provider Identifier);

2) First and last name;

3) Specialty type;

4) Group association;

5) Full address;

6) Telephone number;

7) Cultural and linguistic services, including provider and provider staff language capability;

8) Hospital admitting privileges; and

9) Provider capacity, including current capacity.

D. After the initial submission of a Medi-Cal provider network report, D-SNP Contractor shall submit an updated report at least:

1) Quarterly; and

2) Whenever a significant change to the network affects provider capacity and services, including changes in:

   a) Services or benefits;

   b) Geographic Service Area or payments; or

   c) Enrollment of a new population.

E. The quarterly report shall include, at a minimum, the following:

1) Network provider deletions:

2) The number of Members assigned to each primary care provider that has been deleted from the network;

3) Network providers who are not accepting new patients; and

4) Provider additions: Each provider addition must include the information prescribed in the initial Medi-Cal provider network report.

7. Medi-Cal and Medicare Eligibility Verification

A. It is D-SNP Contractor's responsibility to:

1) Confirm Medicare Advantage and Medi-Cal eligibility;

2) Verify Medi-Cal eligibility of a Member, Medi-Cal agrees to provide D-SNP Contractor with real-time ac**c**ess to the Medi-Cal's eligibility verification system;

~~3) Confirm all applicable Medicare Advantage special needs criteria are met, based on D-SNP type.~~

B. Contractor must validate Medicare Advantage and Medi-Cal eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a Cal MediConnect plan or Medi-Cal MCP at the time of the inquiry.

2) If neither the Medicare and/or Medi-Cal eligibility systems indicate current or pending Cal MediConnect or MCP enrollment, the beneficiary may be enrolled in the Contractor's D-SNP.

Exhibit A
SCOPE OF WORK

C. **D-SNP Contractor shall ensure appropriate training of plan personnel and providers regarding the use of the Medi-Cal eligibility verification system interface and the appropriate interpretation of its eligibility results.**

8. Contract Term

This D-SNP Contract shall be effective from January 1, 2017 through December 31, 2021~~4~~**3**.

9. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

10. Compensation

The State of California and DHCS shall not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

11. Centers for Medicare ~~and~~ & Medicaid Services Documentation

Contractor shall submit to DHCS a complete and accurate copy of the bid ~~submitted to~~ **as approved by** CMS.

If not included in the approved bid, the D-SNP Contractor also will provide to DHCS the following information, in a format as specified by DHCS, upon execution of this contract and annually thereafter on the last day of June:

1) The current approved Model of Care.

2) A list of approved Supplemental Benefits.

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GTC 307 **Exhibit C**

GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by the Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., Title 2 CCR Section 1896).

5. INDEMNIFICATION: Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Agreement.

6. DISPUTES: Contractor shall continue with the responsibilities under this Agreement during any dispute.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. All costs to the State shall be deducted from any sum due the Contractor under this Agreement and the balance, if any, shall be paid to the Contractor upon demand.

8. INDEPENDENT CONTRACTOR: Contractor, and the agents and employees of Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer material as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Title 2 CCR Chapter 5 of Division 4, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

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GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, the Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. Contractor will, in all solicitations or advancements for employees placed by or on behalf of Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal g overnment or the State, advising the labor union or workers' representative of Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance

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Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G . Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, the D-SNP Contractor may request in writing to DHCS, who, in turn, may request the

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of Contractor, Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

A. It is mutually understood between the parties that this D-SNP Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the D-SNP Contract were executed after that determination was made.

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

~~B. This D-SNP Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this D-SNP Contract. In addition, this D-SNP Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress that may affect the provisions, terms or funding of this D-SNP Contract in any manner.~~

~~C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this D-SNP Contract shall be amended to reflect any reduction in funds.~~

~~D. DHCS has the option to invalidate or cancel the D-SNP Contract with 30-days advance written notice or to amend the D-SNP Contract to reflect any reduction in funds.~~

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 USC 1857(h)], section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either

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receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

B. Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out Contractor's obligations under this D-SNP Contract.

C. Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information,

diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three (3) year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein; and

4) Have not within a three (3) year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default.

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children’s services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this D-SNP Contract, Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

21. Covenant Against Contingent Fees

Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this D-SNP Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

27. Use of Small, Minority Owned and Women's Businesses

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or subgrant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information

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reported includes:

a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Title 31 USC Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Care Coordination or Coordination of Care** means the identification of a medical condition that requires referral for Medi-Cal benefits or services that are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates.

2. **Confidential Information** means specific facts or documents identified as “confidential" by any law, regulations or contractual language.

3. **Coordinated Care Initiative (CCI)** means an initiative that includes a three-year Duals Demonstration project (Cal MediConnect) for beneficiaries who are dually eligible for Medicare and Medi-Cal (Duals) to combine the full continuum of acute, primary, institutional, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system. CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 34, Statutes of 2013), and includes a mandatory Medi-Cal managed care enrollment for Duals, and the inclusion of long-term services and supports (LTSS) as Medi-Cal managed care benefits for Seniors and Persons with Disabilities (SPD) beneficiaries who are eligible for Medi-Cal only, and for Dual SPD beneficiaries. CCI counties include Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

4. **Covered Service(s) or covered service(s)**, as used in this contract, means care coordination or coordination of care. This is the only service covered under this contract.

5. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

6. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

7. **Department of Health and Human Services (DHHS)** means the Federal agency responsible for management of the Medicare and Medicaid programs.

8. **Director** means the Director of the California Department of Health Care Services.

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Exhibit E, Attachment 1
DEFINITIONS

9. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and**/or** Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

10. **Enrollment** means the process by which a beneficiary eligible for enrollment as contained in Exhibit A, Attachment 1, Provision 3 becomes a Member of the Contractor's D-SNP.

11. **Facility** means any premise that is:

    A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or

    B. Maintained by a Provider to provide services on behalf of Contractor.

12. **Medi-Cal Managed Care Health Plan** means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

13. **Member** means any beneficiary who is enrolled in the Contractor's D-SNP.

14. **Service Area** means the geographic area in which Members or potential Members reside and for whom Contractor is approved to provide services by CMS.

15. **State** means the State of California.

16. **Working day(s)** mean State calendar (State Appointment Calendar, Standard101) working day(s).

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, D-SNP Contractor also agrees to the following:

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

   Any provision of this D-SNP Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the D-SNP Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

B. Such amendment shall constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

~~C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/ June 14, 2002, at 42 CFR, 400, 430, 431, 434, 435, 438, 440 and 447. D-SNP Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.~~

~~D~~**C.** All existing final Policy Letters issued by MMCD or the current Managed Care Operations Division (MCOD) can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx and shall be complied with by D-SNP Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this D-SNP Contract shall

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provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and a MMCD or MCOD Policy Letter or All Plan Letter, the D-SNP Contract shall prevail.

2. Entire Agreement

This written D-SNP Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the D-SNP Contract.

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

Should either party, during the life of this D-SNP Contract, desire a change in this D-SNP Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this D-SNP Contract which would provide for the change. If the proposal is accepted, this D-SNP Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

D-SNP Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal guidelines, or judicial interpretation, DHCS may direct D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, D-SNP Contractor will be obligated to implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer". The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 14, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program reside with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of Contractor's Duties and Obligations Under this D-SNP Contract

D-SNP Contractor shall not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 18.

~~**9. Prohibition Against Subcontracts**~~

~~D-SNP Contractor shall not enter into subcontracts, regardless of the cost of services reimbursed under the D-SNP Contract, and DHCS shall not approve any subcontracts for the provision of care coordination services.~~

~~10~~9. Prohibition Against Novations

D-SNP Contractor and DHCS shall not enter any novation agreements. Contractor shall not propose any novation agreements nor shall DHCS agree to or act upon any proposal.

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~~11~~10. Obtaining DHCS Approval

D-SNP Contractor shall obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval.

~~12~~11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

~~13~~12. Certifications

D-SNP Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

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~~14~~13. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed to have been given when mailed to DHCS or the D-SNP Contractor:

California Department of Health Care Services
Managed Care Operations Division
MS 4408
P.O. Box 997413
Sacramento, CA 95899-7413

California
Attn: President
CA

~~15~~14. Term

The D-SNP Contract will become effective January 1, 20XX, and will continue in full force and effect through December 31, 20XX.

~~16~~15. Service Area

The Service Area covered under this D-SNP Contract includes:
County

All D-SNP Contract provisions apply separately to each Service Area.

~~17~~16. D-SNP Contract Extension

DHCS may extend this D-SNP Contract for any reason.

~~18~~17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. Termination - State or Director

1) DHCS may terminate performance of work under this D-SNP Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

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2) Notification shall be given at least 60 days prior to the effective date of termination, except in cases described below in Paragraph B, Termination for Cause.

B. Termination for Cause

1) DHCS shall terminate this D-SNP Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the D-SNP Contract, the D-SNP Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination. Except for termination pursuant to this Paragraph B, item 3) below, D-SNP Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 19, Disputes. Termination of the D-SNP Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides D-SNP Contractor with at least 60 calendar days' notice of termination. The termination of this D-SNP Contract shall be effective on the last day of the second full month from the date of the notice of termination. D-SNP Contractor agrees that 60 calendar days' notice is reasonable.

3) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under the contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

C. Termination - D-SNP Contractor

Grounds under which D-SNP Contractor may terminate this D-SNP Contract are limited to when a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the conditions under which D-SNP Contractor entered into this D-SNP Contract, such that D-SNP Contractor can demonstrate to the satisfaction of DHCS.

D. Termination of Obligations

All obligations to provide services under this D-SNP Contract will automatically terminate on the date the operations period ends.

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~~19~~18. Disputes

In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

This Disputes section will be used by D-SNP Contractor as the means of seeking resolution of disputes on contractual issues.

A. Disputes Resolution by Negotiation

DHCS and D-SNP Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

1) Within 15 calendar days of the date the dispute concerning performance of this D-SNP Contract arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

2) D-SNP Contractor's notification will state, on the basis of the most accurate information then available to D-SNP Contractor, the following:

a) That it is a dispute pursuant to this section.

b) The date, nature, and circumstances of the conduct which is subject of the dispute.

c) The names, phone numbers, function, and activity of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

d) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

e) The reason D-SNP Contractor is disputing the conduct.

f) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

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g) D-SNP Contractor's desired remedy.

3) The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by D-SNP Contractor. This documentation will serve as the basis for any subsequent appeal.

4) Following submission of the required notification, with supporting documentation, the D-SNP Contractor will comply with the requirements of Title 22, CCR, Section 53851(d) and diligently continue performance of this D-SNP Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

h) Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by D-SNP Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this D-SNP Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

a. Find in favor of D-SNP Contractor, in which case the Contracting Officer or alternate dispute officer may countermand the earlier conduct which caused D-SNP Contractor to file a dispute; or

b. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

c. Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise D-SNP Contractor as to what additional information is required, and establish how that information shall be furnished. D-SNP Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by D-SNP

Contractor of all claims in accordance with Paragraph F, Waiver of Claims, below.

A copy of the decision shall be served on D-SNP Contractor.

i) Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

D-SNP Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include D-SNP Contractor's contentions as to those issues. However, D-SNP Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B, Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, D-SNP Contractor shall exhaust all procedures provided for in this Provision 19, Disputes, prior to initiating any other action to enforce this D-SNP Contract.

j) D-SNP Contractor Duty to Perform

Pending final determination of any dispute hereunder, D-SNP Contractor shall comply with the requirements of Title 22, CCR, Section 53851(d) and proceed diligently with the performance of this D-SNP Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision. If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision above, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph D, shall be retroactive to the date of the Contracting Officer’s or alternate dispute officer’s decision, and D-SNP Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer’s or alternate dispute officer’s decision or any appeal of such decision.

k) Waiver of Claims

If D-SNP Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required

information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19, Disputes, that failure shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

~~20~~19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor also agrees to the following:

The D-SNP Contractor will maintain such books and records necessary to disclose how D-SNP Contractor discharged its obligations under this D-SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which Contractor administered its daily business.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D-SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining Covered Services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this D-SNP Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the D-SNP Contract is terminated, or, in the event D-SNP Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the D-SNP Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

~~21~~20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

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PROGRAM TERMS AND CONDITIONS

Through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of D-SNP Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of D-SNP Contractor and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during D-SNP Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the D-SNP Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to D-SNP Contractor. This will include the Management Information System operations site or such other place where duties under the D-SNP Contract

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are being performed.

Staff designated by authorized State agencies will have access to all security areas and D-SNP Contractor will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of D-SNP Contractor.

~~22~~21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

C. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by D-SNP Contractor from unauthorized disclosure.

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for Medical Records made in accordance with applicable law. Exhibit G is hereby incorporated into this contract by reference.

D. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by D-SNP Contractor, D-SNP Contractor:

1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical records in accordance with applicable law;

3) Will not disclose except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to D-SNP Contractor by DHCS for this purpose.

~~23~~21. Third-Party Tort Liability

D-SNP Contractor shall identify and notify DHCS' Third Party Liability and Recovery Branch of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor shall deliver the requested information within 30 calendar days of the request.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor shall identify to DHCS' Third Party Liability and Recovery Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D . If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor shall refer the request to the Third Party Liability and Recovery Branch with the

information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to:

California Department of Health Care Services
Third Party Liability and Recovery Branch, Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425.

~~24~~23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor shall:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such request shall include, but is not limited to a response to a request for documents submitted by any party in any litigation by or against DHCS D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract entered into under this D-SNP Contract.

~~25~~24. Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of D-SNP Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of D-SNP Contractor's commitment as an equal opportunity employer and will post

copies of the notice in conspicuous places available to employees and applicants for employment.

~~26~~25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor shall not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56 in accordance with the statues identified in Exhibit E, Attachment 2, Provision 27 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination may include, but is not limited to, the following:

1) Denying any Member any Covered Services;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability.

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Enrollees.

D-SNP Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

D-SNP Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member’s health.

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~~27~~26. Federal and State Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

~~28~~27. D-SNP Contractor shall process a grievance for discrimination as required by federal and ~~state~~ **State nondiscrimination** law as stated in 45 CFR section~~s~~ 84.7 ~~and 92.7~~; 34 CFR section 106.8; 28 CFR section 35.107; and~~, to the extent applicable,~~ W&I Code section 14029.91(e)(4).

A. D-SNP Contractor shall designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. D-SNP Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor shall not require a Member or potential enrollee to file a discrimination Grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor shall submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination grievance;

2) The provider's or other accused party's response to the discrimination grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on

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behalf of D-SNP Contractor;

4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

D. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in **a conspicuously visible font size in English,** the threshold languages**,** and at least the top ~~16~~ **15** non-English languages in the State, **and any other languages,** as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation**, and information on how to request Auxiliary Aids and services, including materials in alternative formats**. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

1) In all conspicuous physical locations where D-SNP Contractor interacts with the public;

2) In a ~~conspicuous~~ location on D-SNP Contractor's website that is accessible on the D-SNP Contractor's home page, and in a manner that allows Members, potential enrollees, and members of the public to easily locate the information; and

3) In **the Evidence of Coverage,** all **Member information, informational notices, and materials critical to obtaining services** ~~significant communications and significant publications~~ targeted to Members, potential enrollees, applicants, and members of the public, ~~except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.~~ (**in accordance with 42 CFR section 438.10(d)(2)-(3) and W&I Code section 14029.91(f)** ~~45 C.F.R. § 92.8(d)(1), (f)(1)(i)-(iii))~~.

~~E. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination statement and (2) language taglines in at least the top two non-English~~

~~languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDD telephone number for obtaining these services, in all significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (45 C.F.R. § 92.8(d)(2), (g)).~~

~~F~~ **E**. D-SNP Contractor's nondiscrimination notice shall include all information required by **W&I Code section 14029.91(e),** ~~Section 92.8 of Title 45 of the Code of Federal Regulations,~~ any additional information required by DHCS, and shall provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation **or identification with any other persons or groups defined in Penal Code 422.56**. (~~45 C.F.R. section 92.8(A)(5);~~ W&I Code section 14029.9~~2~~**1**(e); H&S Code section 11135).

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (~~45 C.F.R. section 92.8(A)(7)~~**W&I Code section 14029.91(e)**).

~~29~~28. Disabled Veteran Business Enterprises (DVBE)

D-SNP Contractor shall comply with applicable requirements of California law relating to DVBE commencing at Section 10115 of the Public Contract Code.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~30~~29. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

~~31~~30. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor shall comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

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Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement

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on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a

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confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible,

Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS

Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request

approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement

and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
6. Consider Reappointment to CalOptima Board of Directors Investment Advisory Committee

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

Recommended Action
Reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning on June 7, 2021.

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

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

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

Discussion
The candidate recommended for reappointment, Rodney Johnson, has consistently provided leadership and service to CalOptima's investment strategies through his participation as an IAC member.

Mr. Johnson has served as a member of the IAC since June 6, 2013. Mr. Johnson has extensive experience working with public agencies. He is currently the Senior Director, Finance-Treasury for Los Angeles County Metropolitan Transportation. He previously worked as the Deputy Treasurer of the Orange County Transportation Authority (OCTA). He has been responsible for daily analysis of short-term and long-term cash flow needs, executing investments, and overseeing five (5) different investment management firms. Prior to that, Mr. Johnson held positions at BNY Western Trust Company, Fund Services Associates, Inc., and Muni Financial Services, Inc. Mr. Johnson has a M.P.A. from California State University Long Beach, and a B.A. from California State University Fullerton. His current term expires on June 6, 2021.

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

Rationale for Recommendation
The individual recommended for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has already provided outstanding service as a member of the IAC.

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

Attachment
None

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Contacts

Belinda Abeyta, Executive Director, Operations, (657) 235-6755
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Action

The CalOptima OneCare Connect Member Advisory Committee (OCC MAC) recommends reappointment of the following individuals to serve two-year terms on the OCC MAC, effective July 1, 2021 through June 30, 2023:

a. Sandra Finestone as the Persons with Disabilities Representative;
b. Josefina Diaz as the Member/Family Member Representative; and
c. Sara Lee as the Persons from Ethnic or Cultural Community Representative

Background

The CalOptima Board of Directors welcomes community stakeholder involvement and benefits from their input in the form of advisory committees. The Centers for Medicare & Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) established requirements for the implementation of the Cal MediConnect program, including a requirement for the establishment of a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OCC MAC by resolution on February 5, 2015, to provide input and recommendations to the CalOptima Board relative to the OCC program, the Cal MediConnect program administered by CalOptima.

The OCC MAC is comprised of 10 voting members, seven of whom represent community seats and three of whom are OCC members or family of OCC members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve. The terms for five OCC MAC seats due to expire on June 30, 2021. These include seats designated for Persons with Disabilities, Persons from an Ethnic or Cultural Community, In-Home Supportive Services/Union Provider, and two OCC Members/Family Member seats.

Discussion

CalOptima staff conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducted targeted community outreach to agencies and CBOs serving the various open positions and posting recruitment materials on the CalOptima website and social media including Facebook and LinkedIn.

The OCC MAC Nominations Ad Hoc, composed of committee members Patty Mouton, Gio Corzo and Meredith Chillemi, met on April 20, 2021, and evaluated each of the applications for the available openings. The ad hoc presented the recommended slate of candidates for the five vacancies to the full committee on April 22, 2021. One OCC MAC Member Representative and an In-Home Supportive Services/Union Provider will remain vacant until eligible candidates sho are able to serve on the committee are identified.

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OCC MAC committee members voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc and are now forwarding the proposed slate of candidates to the CalOptima Board of Directors for consideration

The candidates for the open positions are:

Member Representative
Josefina Diaz*
Josefina Diaz has a parent who is a OCC member. Ms. Diaz has many years of experience working in the Orange County community. She currently works as a paralegal with the Community Legal Aid SoCal (CLA SoCal) formerly known as the Legal Aid Society of Orange County. Ms. Diaz's work with CLA SoCal has provided her with knowledge and experience working with a diverse community. Ms. Diaz has been an OCC MAC member since 2016.

Persons with Disabilities Representative
Sandra Finestone*
Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators. Dr. Finestone works daily with individuals who have become disabled due to stage IV cancer. She facilitates support groups, meets individually with patients and their families and has created a peer support system. Ms. Finestone has been involved with the delivery of health care in the community for more than 30 years, both as an advocate and as a health care provider. Dr. Finestone also holds a seat on the Member Advisory Committee (MAC).

Persons From an Ethnic or Cultural Community Representative
Sara Lee*
Sara Lee is an attorney at the Community Legal Aid SoCal (CLA SoCal). She has been an attorney at CLA SoCal since December 2003. She is currently the Supervising Attorney of the Health Consumer Action Center (HCAC) unit at CLA SoCal, a partner of the statewide Health Consumer Alliance. She is a member of CalOptima's OCC MAC serving as the Ethnic and Cultural Community representative. She also serves as a steering committee member of Covered OC. She received her Juris Doctorate from the Southwestern University of Law and her Bachelor of Arts degree in political science from the University of California, Irvine (UCI). She has been a member of OCC MAC since 2015.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the OCC MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The OCC MAC met on April 22, 2021 to discuss the Ad Hoc's recommended slate of candidates and concurred with the Ad Hoc's recommendations. The OCC MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

*Indicates OCC MAC recommendation

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Concurrence
OneCare Connect Member Advisory Committee Nominations Ad Hoc
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

*Indicates OCC MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

Contacts

Belinda Abeyta, Executive Director, Operations, (657) 235-6755
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

The CalOptima Member Advisory Committee (MAC) recommends:

1. Reappointment of the following individuals to serve two-year terms on the MAC, commencing on July 1, 2021 and ending on June 30, 2023;
    a. Sandra Finestone as the Adult Beneficiaries Representative;
    b. Maura Byron as the Family Support Representative; and
    c. Hai Hoang as the Persons with Disabilities Representative.

2. Appoint Meredith Chillemi to the MAC to serve as the Seniors Representative for a two-year term commencing on July 1, 2021 and ending on June 30, 2023

Background

The CalOptima Board of Directors established the MAC by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms except for the two standing seats, which are representatives from the Orange County Social Services Agency (SSA) and the Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members. With the fiscal year ending on June 30, 2021, four MAC seats will expire: Adult Beneficiaries, Family Support, Persons with Disabilities and Seniors.

Discussion

CalOptima conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducted targeted community outreach to agencies and CBOs serving the various open positions and posting recruitment materials on the CalOptima website as well as CalOptima's social media accounts for LinkedIn and Facebook.

The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Sally Molnar, Patty Mouton, Steve Thronson and Christine Tolbert evaluated each of the applicants for the MAC openings and forwarded the proposed slate of candidates for the five vacancies to the full MAC for their consideration of a recommendation to the Board.

At the May 13, 2021 Special MAC meeting, MAC members accepted the recommended slate of candidates as proposed by the Nominations Ad Hoc and requested that the proposed slate of candidates be forwarded to the CalOptima Board for consideration

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The candidates for the open positions are as follows:

Adult Beneficiaries Candidates

Sandra Finestone*

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators. Ms. Finestone works with individuals who have become disable due to stage IV cancer and facilitates support groups, meets individually with patients and their families and has created a peer support system. Ms. Finestone has been involved with the delivery of health care in the community for over 30 years, both as an advocate and as a health care provider. Ms. Finestone is also a current committee member of CalOptima's OneCare Connect Member Advisory Committee (OCC MAC) as the Persons with Disabilities Representative since 2015. She has been a member of the MAC since 2013.

Family Support Representative Candidates

Maura Byron*

Ms. Byron is the Executive Director of the Family Support Network and is the parent of a young adult who is a current California Children's Services client. As the executive director, she assists families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support. Ms. Byron also serves on CalOptima's Whole-Child Model Family Advisory Committee since 2018. She has been a member of the MAC since 2020 when she was appointed to fulfill an existing term.

Persons with Disabilities Candidates

Hai Hoang*

Mr. Hoang is currently the Chief Operating Officer at the Illumination Institute working directly with CalOptima's youth, disabled and adult/older adult populations. Presently the Illumination Institute continues a parent mentoring program for children with intellectual/developmental disabilities and their families that was established by Mr. Hoang when he was with Boat People SOS. The Illumination Institute also works with the Garden Grove and Santa Ana school districts assisting the medical and mental health support of children. Mr. Hoang has worked with the Vietnamese community since 2009 assisting children with intellectual/developmental disabilities and their families with health care navigation. Mr. Hoang has been a life-long advocate of the persons with disabilities population of Orange County for their medical and behavioral health needs. He currently holds the MAC Persons with Disabilities seat having been appointed to fill an existing term in 2020.

Lee Lombardo

Lee Lombardo is the current executive Director of YMCA Community Services. She is a Licensed Clinical Social Worker (LCSW). Ms. Lombardo has worked in mental health with children, teens, families and adults including co-occurring mental health/developmental disabilities. She also works with Orange County agencies as well as state agencies on the Developmental Screening Cohort through Help Me Grow OC, the Child Development and Planning Council Committee and Inclusion Subcommittee as well as the Be Well OC Prevent and Act Early Workgroup.

*Indicates MAC recommendation

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Seniors Candidates

Meredith Chillemi*

Meredith Chillemi is the LifeSTEPS Director of Aging and Education Services where she provides direct service to CalOptima dual eligible older adults residing in affordable housing communities in Westminster, Brea and San Clemente. As a lead at LifeSTEPS, she guides programs at 10 senior affordable housing apartment communities in Orange County and regularly collaborates with community-based adult services (CBAS), senior centers, the Office on Aging and serves on the County of Orange Senior Citizens Advisory Council Health and Nutrition Committee. Ms. Chillemi also serves on the OCC MAC as the Long-Term Services and Supports Representative since 2020.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

As stated in policy, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc's recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence

Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

*Indicates MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

The Provider Advisory Committee (PAC) recommends the following appointments to the PAC for three-year terms ending June 30, 2024:

1. New appointment of Gio Corzo as the Allied Health Representative;
2. New appointment of Jacob Sweidan, M.D. as the Health Network Representative;
3. Reappointment of Junelyn Lazo-Pearson, Ph.D, as the Behavioral/Mental Health Representative; and
4. Reappointment of Tina Bloomer as the Nurse Representative.

Background

The CalOptima Board of Directors established the Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The PAC is comprised of 15 voting members. Pursuant to resolution no. 15-0806-03, PAC members serve three-year terms with the exception of one standing seat, which is occupied by a representative from the Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all PAC members. With the fiscal year ending on June 30, 2021, four PAC seats will expire: Allied Health, Behavioral/Mental Health, Health Networks and Nurse Representatives.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment process included notification methods including sending outreach emails to community-based organizations and targeting community outreach to agencies serving the various open positions. Recruitment also consisted of emails to health networks, long-term care facilities, behavioral/mental health providers, physicians and hospitals in order to reach all CalOptima providers for all open seats. Open seats were also posted on CalOptima's social media platforms, which included LinkedIn and Facebook for recruitment purposes. CalOptima staff received applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on April 28, 2021, subcommittee members evaluated each of the applicants. The subcommittee, including Vice Chair Nishimoto, Jennifer Birdsall, Teri Miranti and Christy Ward, selected a candidate for each of the open seats and forwarded the proposed slate of candidates to the PAC for consideration.

At the May 13, 2021 meeting, the PAC voted to accept the recommended slate of candidates proposed by the Nominations Ad Hoc Subcommittee.

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The slate of candidates are:

Allied Health Representative
Gio Corzo*
Mr. Corzo is the Vice President of Home & Care Services for Meals on Wheels. He has more than 20 years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including community-based adult services (CBAS) centers, day programs and residential long-term care facilities. Mr. Corzo was instrumental in working on the state transition of adult day health care to CBAS. Mr. Corzo also served a two-year term on the OneCare Connect Member Advisory Committee as chair since 2015.

Behavioral/Mental Health Representative
Junelyn Lazo-Pearson, Ph.D.*
Dr. Lazo-Pearson is the Executive Advisor to Advanced Behavioral Health, Inc., a CalOptima contracted behavioral health group. She also serves part-time as an adjunct professor for the Chicago School of Professional Psychology, Irvine Campus, in Irvine. Dr. Lazo-Pearson holds a Ph.D. in Developmental and Child Psychology and is a Board-Certified Behavior Analyst through the Behavior Analyst Certification Board. A member of PAC since 2018, she currently serves as the PAC Chair.

Health Networks
Jacob Sweidan, M.D.*
Dr. Sweidan is the President at Noble Mid-Orange County, a contracted health network with CalOptima. He is also a practicing pediatrician with four offices in Anaheim, Garden Grove and Santa Ana serving CalOptima patients since the agency's inception. Dr. Sweidan previously served on the PAC from 2009 to 2020 as a Physician Representative and previously served on CalOptima's Quality Assurance Committee.

Kevin Rey
Kevin Rey is currently the Manager of Government Programs for Monarch HealthCare where he began his career in 2003. He holds a B.S. in Biological Sciences from the University of Nevada, Las Vegas. At Monarch, Mr. Rey has been responsible for the implementation of new programs such as the Whole-Child Model, Health Homes Program and Monarch's annual delegation audit, and will be managing the implementation of CalAIM.

Nurse Representative
Tina Bloomer, WHNP, FNP, MSN*
Ms. Bloomer is currently a Nurse Practitioner with University of California, Irvine Medical Center in Orange where she specializes in high-risk obstetrics. Ms. Bloomer has 25 years of experience providing quality health care services to underserved communities and received the Provider of the Year Award for 2014–15, and Excellence in Quality Award in 2015, 2016 and 2017 when she was with AltaMed Health Care. She is a top-ranking provider for Women's Health HEDIS measures. Ms. Bloomer holds an M.S. degree in Nursing Science and a degree as a Family Nurse Practitioner from the University of Phoenix. In addition to being Six Sigma Certified, Ms. Bloomer also holds a Drug Enforcement Agency

*Indicates PAC recommendation

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(DEA) License, Nurse Practitioner Furnishing License and a National Provider Identifier (NPI) Certification. Ms. Bloomer has served on the PAC since 2019 where she fulfilled an existing term that will expire on June 30, 2021.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in CalOptima policy AA.1219b, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committee. The PAC met to discuss the recommended slate of candidates and concurred with the subcommittee's recommendations. The PAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence
Provider Advisory Committee Nominations Ad Hoc Subcommittee
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None.

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

*Indicates PAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Appointments to the CalOptima Board of Directors' Whole-Child Family Advisory Committee

Contacts

Belinda Abeyta, Executive Director, Operations, (657) 235-6755
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

The Whole-Child Model Family Advisory Committee (WCM FAC) recommends the following appointments to the WCM FAC for terms ending June 30, 2023:

1. Reappointment of the following individuals, effective upon Board approval:
    a. Monica Maier as an Authorized Family Member Representative;
    b. Malissa Watson as an Authorized Family Member Representative;
    c. Sandra Cortez-Schultz as a Community-Based Organization Representative; and
2. New Appointment of Kathleen Lear as an Authorized Family Member Representative

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016 and authorized the establishment of the Whole-Child Model incorporating California Children's Services (CCS) covered services for Medi-Cal eligible children and youth into specified county-organized health system plans, including CalOptima. A provision of the WCM program requires each participating health plan to establish a FAC. Accordingly, the CalOptima Board of Directors established the WCM FAC by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, seven to nine of whom are to be designated as family representatives and two to four of whom are to be designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill those seats.

Discussion

CalOptima staff conducted comprehensive outreach, including sending notifications to community-based organizations (CBOs), as well as conducted targeted community outreach to agencies and CBOs serving the various open positions and posting recruitment materials on the CalOptima website, as well as CalOptima's social media sites such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2021, seven WCM FAC seats will expire: five Authorized Family Member Representatives and two Community-Based Organization/Consumer Advocate Representatives.

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The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC committee members Maura Byron, Brenda Deeley and Kristen Rogers met on April 22, 2021. They evaluated each of the applications for the upcoming openings and proposed a slate of candidates that was forwarded to the WCM FAC committee for consideration.

At its April 27, 2021 regular meeting, the WCM FAC accepted the recommended slate of candidates and requested it be forwarded to the Board for consideration. Two Authorized Family Member Representative seats and one Consumer Advocate seat will remain vacant until eligible candidates are identified.

The candidates for the open positions are as follows:

Authorized Family Member Representative

Kathleen Lear (New Appointment)

Ms. Lear is the parent of a special needs child who has recently been approved to receive CCS services Ms. Lear is a substitute instructional assistant to special education children in the Los Alamitos Unified School District, and she is a member of the Family Advisory Committee at Children's Hospital of Orange County (CHOC). Ms. Lear is also a parent champion for C.O.P.E. where she helps provide support for families living with epilepsy. Ms. Lear was appointed to the WCM FAC as a Consumer Advocate in October 2019. With the addition of CCS services for her child, she would like to participate on the committee as an Authorized Family Member.

Monica Maier (Reappointment)

Monica Maier is the stepmother and main caregiver of a child who receives CCS services. Ms. Maier continues to advocate on behalf of parents and their children with CCS conditions. She has been a member of the WCM FAC since February 2020, when she was appointed to fill an existing term that would expire June 30, 2021.

Malissa Watson (Reappointment)

Malissa Watson is the mother of a child who receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. She is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents. She has been a member of the WCM FAC since its inception in 2018.

Community-Based Organization Representative

Sandra Cortez-Schultz (Reappointment)

Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has more than 25 years of experience working directly and indirectly at varying levels with the CCS program. She has been a member of the WCM FAC since its inception in 2018.

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Fiscal Impact
Each authorized family member representative appointed to the WCM FAC may receive a stipend of up to $50 per committee meeting attended. Funding for stipends provided to WCM FAC family representatives is a budgeted item under the CalOptima Fiscal Year 2020–21 Operating Budget. Management will include funding related to the stipends in the upcoming FY 2021–22 and future operating budgets. There is no additional fiscal impact related to the recommended actions.

Rationale for Recommendation
As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancy on the Committee. The WCM FAC met on April 27, 2021, to discuss and concurred with the subcommittee's recommendations. The WCM FAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Consider Selecting and Contracting with Investment Managers for CalOptima's Operating, Tier One and Tier Two Investment Accounts; Authorize Allocation of these Assets Amongst the Recommended Investment Managers

Contact

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

Recommended Actions

1. Approve recommended investment managers, MetLife Investment Management and Payden & Rygel for investment management services;
2. Authorize the Chief Executive Officer (CEO), with assistance of Legal Counsel, to enter into contracts with the recommended investment managers, with each contract for a three-year term, with two one-year extension options, each extension option exercisable at CalOptima's sole discretion; and
3. Authorize the allocation of management responsibility for the Operating, Tier One, and Tier Two investment accounts on a 50%/50% basis between the two selected investment managers.

Background

At its March 5, 2015 meeting, the CalOptima Board of Directors directed staff to conduct a Request for Proposal (RFP) process consistent with the Board-approved purchasing policy, for investment manager services, and return to the Board with recommendations after vetting with the Investment Advisory Committee (IAC) and the Finance and Audit Committee (FAC).

Consistent with the Board-approved purchasing policy, Staff conducted an RFP process for investment management of CalOptima Operating and Tier One assets. At the July 27, 2015, IAC meeting, CalOptima's Investment Advisor, Meketa Investment Group presented the results of the Fixed Income Manager Search. Based on the results of the RFP process, the Evaluation Team recommended the selection of Logan Circle Partners.

At the October 26, 2015, meeting, the IAC approved the recommended actions to authorize a contract with an additional investment manager for CalOptima's Operating and Tier One investment accounts, and the allocation of these assets 50%/50% between the current investment manager, Payden & Rygel, and the additional investment manager, Logan Circle Partners.

At the November 19, 2015, meeting, the FAC modified the IAC's original recommendation to have a 33%/33%/33% split of the Operating and Tier One assets and to add one more investment manager. Based on the revised recommended action and the results from the RFP process, Wells Capital was selected as the additional investment manager.

At the December 3, 2015, meeting, the Board authorized contracts with two additional investment managers selected through an RFP process for investment manager services, Logan Circle Partners and

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Wells Capital. The Board also authorized the allocation of management responsibility for the Operating and Tier One investment accounts on an equal basis between the three investment managers.
At the April 25, 2016, meeting, the IAC approved the 100% security in-kind transfer for both Operating and Tier One assets to Logan Circle and Wells Capital, CalOptima's new investment managers. Payden & Rygel distributed 67% of Operating and Tier One assets in equal amounts to Logan Circle and Wells Capital in equal amounts. In addition, the IAC approved a three (3) month rotation period for investment manager cash flows.

At its March 4, 2021, meeting, the Board directed staff to conduct another RFP process for investment manager services, consistent with the Board-approved purchasing policy, and to return to the Board with recommendations after review and approval by the IAC and FAC. The current investment manager contracts expire on September 30, 2021.

Discussion

Consistent with the Board-approved purchasing policy, Staff conducted an RFP process for investment manager services of CalOptima's Operating, Tier One, and Tier Two assets. The following table provides more details on the RFP process.

<table>
<tr><th>Date</th><th>Action</th></tr>
<tr><td>January 2021</td><td>• Developed Scope of Work
• Formed Evaluation Team comprised of CalOptima staff, CalOptima Purchasing, Meketa Investment Group, IAC member
• Issued RFP on January 30, 2021</td></tr>
<tr><td>March 2021</td><td>• Received proposals from sixteen firms
• Evaluation Team reviewed proposals
• Evaluated and ranked proposals based on established criteria
• Evaluation Team conducted interviews with five firms in March and April</td></tr>
<tr><td>April 2021</td><td>• Evaluation Team scored the finalist firms after interviews were completed and determined the final rankings

Firm — Final Score
MetLife Investment Management — 56.83
Payden & Rygel — 55.00
PFM Asset Management — 52.83
Wells Fargo Asset Management — 51.33
Western Asset Management — 45.50</td></tr>
</table>

The Evaluation Team discussed different options to re-balance CalOptima's Operating, Tier One, and Tier Two assets, as well as the appropriate number of investment managers to effectively manage the balance. Evaluations were based on the portfolio balance forecast, returns on investment, reporting capabilities, and investment manager fees. The Evaluation Team also discussed the rotation period for investment manager cash flows.

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Based on these discussions, the Evaluation Team recommends reducing the total number of investment managers from three to two and that the Board authorize contracts with the two highest ranking firms based on the RFP process results, MetLife Investment Management and Payden & Rygel.

Based on feedback from the current investment managers and Meketa Investment Group, Staff recommends increasing the cash flow rotation period for investment managers from three (3) months to six (6) months. This change will lengthen the cash flow rotation period to provide increased investment opportunities, while at the same time be short enough to limit diversification in account balances between investment managers.

At its April 26, 2021, meeting, the IAC reviewed the RFP results and the Evaluation Team's recommendations and recommended that the FAC recommend these actions to the Board of Directors.

At its May 20, 2021, meeting, the FAC recommended that the Board authorize execution of contracts with the recommended vendors for three-year terms, each with two one-year extension options.

Fiscal Impact

Based on the RFP results, Management anticipates that the proposed investment manager fees will not increase the overall investment manager expenses from Fiscal Year (FY) 2020-21 to FY 2021-22. Anticipated investment manager fees associated with the recommended actions will be included in the FY 2021-22 Operating Budget and future operating budgets.

Rationale for Recommendation

The proposed plan supports CalOptima's investment goals to maintain safety of principal, sufficient liquidity to meet the organization's operating needs, and achieving a market rate of return by keeping transaction costs low. To ensure that CalOptima's investment portfolio is optimally managed, approval of the implementation plan for investment managers is recommended.

Concurrence

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

Attachments

1. Entities Covered by the Recommended Actions
2. Proposed CalOptima Contract with MetLife Investment Management
3. Proposed CalOptima Contract with Payden & Rygel

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Payden & Rygel*	333 S. Grand Ave	Los Angeles	CA	90071
MetLife Investment Management*	One MetLife Way	Whippany	NJ	07981
Chandler Asset Management	6225 Lusk Blvd	San Diego	CA	92121
Garcia Hamilton & Associates, L.P.	1401 McKenney, Ste 1600	Houston	TX	77010
Insight Investment Management Limited	200 Park Avenue, 7th flr	New York	NY	10166
Lord Abbett & Co. LLC	90 Hudson St	Jersey City	NJ	07302
Neuberger Berman	1290 Avenue of the Americas	New York	NY	10104
PFM Asset Management, LLC	601 S. Figueroa St. Ste 4500	Los Angeles	CA	90017
RBC Global Asset Management (U.S.) Inc.	50 S Sixth Street, Ste 2350	Minneapolis	MN	55402
Reams Asset Management	227 Washington St	Columbus	IN	47201
Sun Life Capital Management (U.S.) LLC	500 Fifth Avenue Ste 2500	New York	NY	10110
T. Rowe Price Associates, Inc.	100 East Pratt St	Baltimore	MD	21202
US Bancorp Asset Management, Inc.	800 Nicollet Mall	Minneapolis	MN	55402
Wellington Management Company, LLP	280 Congress St	Boston	MA	02210
Wells Fargo Asset Management	525 Market St Flr 12	San Francisco	CA	94105
Western Asset Management Company, LLC	385 East Colorado Blvd	Pasadena	CA	91101

*Entities recommended

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CONTRACT NO. 21-10216
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
METLIFE INVESTMENT MANAGEMENT HOLDINGS, LLC dba
METLIFE INVESTMENT MANAGEMENT, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the 1st day of October 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Metlife Investment Management, LLC, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Investment Management Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 21-031, inclusive of any revisions, amendments and addenda thereto; (iii) CONTRACTOR's Best and Final Offeror's email on April 05, 2021; (iv) CONTRACTOR's proposal dated March 04, 2021; and (v) CONTRACTOR's material presented to CalOptima on March 31, 2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope

of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated March 04, 2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Scott Pavlak	Portfolio Manager / Head of Short Duration Fixed Income
Juan Peruyero	Portfolio Manager / Short Duration Fixed Income
David Wheeler	Credit Sector Strategist / Short Duration Fixed Income
John Palphreyman	Structure Products Sector Strategist / Short Duration Fixed Income
Stephen Kelly	Credit Trader / Short Duration Fixed Income
Kimberley Slough	Municipal Sector Strategist / Short Duration Fixed Income
Phillip Tran	Government Trader / Short Duration Fixed Income
Erin Klepper	Portfolio Specialist / Short Duration Fixed Income
Fern Hyppolite	Portfolio Specialist / Short Duration Fixed Income
Benjamin Epstein	Portfolio Specialist / Short Duration Fixed Income
Daniel Perullo	Head of Global Consultant Relations – Institutional Client Group

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.7 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.8 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, and employees (individually and collectively referred to as "Indemnified Parties") for any loss or damages including but not limited to property damage, bodily injury, or death or any other element of any kind or nature caused by the CONTRACTOR, its officers, employees, or subcontractors, (the "Indemnitors") gross negligence, willful misconduct, violation of law or material breach of a term of this Contract, arising from the performance of the Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but

not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.4 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another

entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion,

sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR

part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.4 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on the 1st day of October, 2021, and shall continue in full force and effect through 09/30/2024, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written

amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required

disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of

CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With

respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the state courts located in the County of Orange, California, unless mandated by law to be brought in federal court, in which case such legal proceedings will be brought in the Central District of California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery

service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Metlife Investment Management, LLC	CalOptima
One Metlife Way	505 City Parkway West
Whippany, NJ 07981	Orange, CA 92868
Attention: Scott Pavlak	Attention: Ryan Prest

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or

unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 21-10216 on the day and year last shown below.

Metlife Investment Management, LLC	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

If CONTRACTOR is a corporation, two officer signatures
or a Corporation Resolution or Corporate Seal is required

Exhibit A
SCOPE OF WORK

A. INVESTMENT MANAGEMENT SERVICES

1. Authority

CONTRACTOR shall have the power to supervise and direct investments for the assets they are provided for the Operating, Tier 1, and Tier 2 Accounts as explained in RFP 21-031, and in making and implementing investment decisions in accordance with the objectives and guidelines specified in CalOptima's Annual Investment Policy. CalOptima hereby appoints CONTRACTOR as its agent and attorney-in-fact with full discretionary authority to buy, sell or otherwise effect investment transactions involving the assets of the Operating, Tier 1, and Tier 2 Accounts in its name, on CalOptima's behalf.

CalOptima hereby authorizes CONTRACTOR to vote any securities held in the Operating, Tier 1, and Tier 2 Accounts in accordance with CONTRACTOR's proxy voting policies in effect from time to time. CalOptima hereby authorizes CONTRACTOR to exercise the rights, options, warrants, conversion privileges, redemption privileges and the tender of securities (collectively, "Corporate Actions") held in the Operating, Tier 1, and Tier 2 Accounts. CalOptima shall cause all proxy, Corporate Action materials and related communications received by it or on its behalf to be delivered to CONTRACTOR on a timely basis. CONTRACTOR will not advise or take any action on behalf of CalOptima or provide advice for any legal proceedings involving securities held in or formerly held in the Operating, Tier 1, and Tier 2 Accounts, including bankruptcies and class actions.

2. Custody

CalOptima has appointed a custodian to hold possession of the assets of the Account and plans to advise the custodian to accept the instructions regarding trades from CONTRACTOR. CONTRACTOR shall not be the custodian.

3. Brokerage

CONTRACTOR may place orders for the execution of transactions with or through brokers, dealers or banks as CONTRACTOR may select (except for itself), and CONTRACTOR is authorized to give such brokers and dealers all instructions that it shall deem appropriate in connection with the actions it is authorized to take as provided herein. CONTRACTOR is authorized to employ such brokers and dealers for the purchase and sale of Operating, Tier 1, and Tier 2 Account assets and, if applicable, to select the brokerage commission rates at which such transactions are affected. CONTRACTOR may give a copy of this Agreement to any broker, dealer or other party to a transaction for the Operating, Tier 1, and Tier 2 Accounts, to CalOptima's custodian as evidence of CONTRACTOR's authority to act for CalOptima. CONTRACTOR shall not be liable for losses incurred by reason of any act or omission on the part of a broker or dealer or the insolvency of a broker dealer.

4. Reports to CalOptima

CONTRACTOR shall send CalOptima an inventory of the investments of the Account as soon as reasonably possible after the end of each month. Copies of the confirmations of transactions executed will be promptly sent to the custodian. CONTRACTOR does not assume responsibility for the accuracy of information furnished by CalOptima or any agent of CalOptima.

5. Communications

Instructions with respect to securities transactions may be given by CalOptima to CONTRACTOR orally, by wire or electronically, and where deemed necessary, may be confirmed in writing as soon as practical. CONTRACTOR shall be fully protected in relying upon any direction in accordance with this section with respect to any instruction, direction or approval of CalOptima.

6. Form ADV

As required by the Advisers Act, CalOptima acknowledges receipt of CONTRACTOR's Form ADV Part 2, or alternate disclosure brochure. Such disclosure document was provided either (i) at least 48 hours prior to entering into this written Agreement or (ii) at the time of entering into this written Agreement with the right to terminate such Agreement, without penalty, within five (5) business days after entering into it by giving written notice of such cancellation to CONTRACTOR.

Exhibit B
PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR firm-fixed fees based on the rates below for fees and expenses in accordance with the provisions of this Exhibit.

B. CONTRACTOR shall invoice CalOptima on a quarterly basis in arrears for its assets under management. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org. Each invoice shall cite Contract No. 21-10216. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed the fee calculations set forth below in Paragraph E, and such fees include all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. This Contract will be paid on an “assets under management’ basis using each month’s average market value. Assets under management shall be derived as the sum of the average market value for each month of the calendar quarter, divided by 3.

Exhibit B-1

Not applicable for this Contract

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Metlife Investment Management, LLC including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: _____

Print Name: _____

Title: _____

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
21-10216	
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____
4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:	
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:	
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____	
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLLA, if necessary*)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____	
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*		
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No		
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL	

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Exhibit F

Not applicable for this Contract

Exhibit G

Not applicable for this Contract

Exhibit H

Not applicable for this Contract

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

Business Entity Type: _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: _____

City:_____ State:_____ Zip:_____

Business Phone:_____ Email: :_____

President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CONTRACT NO. 21-10211
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
PAYDEN & RYGEL
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the 1st day of October 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Payden & Rygel, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Investment Management Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 21-031, inclusive of any revisions, amendments and addenda thereto; (iii) CONTRACTOR's Best and Final Offeror's email on April 09, 2021; (iv) CONTRACTOR's proposal dated March 04, 2021; and (v) CONTRACTOR's material presented to CalOptima on March 31, 2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated March 04, 2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Asha Joshi	Managing Director
Kerry Rapanot	Sr. Vice President
Adam Congdon	Sr. Vice President

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per claim: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever caused by negligent acts, errors or omissions or willful misconduct by the Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single

transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and

its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive

Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way

diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on the 1st day of October, 2021, and shall continue in full force and effect through 09/30/2024, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the

same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result

of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party

may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Payden & Rygel	CalOptima
333 South Grand Ave.	505 City Parkway West
Los Angeles, CA 90071	Orange, CA 92868
Attention: Asha Joshi	Attention: Ryan Prest

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the

duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's

failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative

agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 21-10211 on the day and year last shown below.

PAYDEN & RYGEL	CALOPTIMA
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

If CONTRACTOR is a corporation, two officer signatures
or a Corporation Resolution or Corporate Seal is required

Exhibit A
SCOPE OF WORK

A. INVESTMENT MANAGEMENT SERVICES

1. Authority

CONTRACTOR shall have the power to supervise and direct investments for the assets they are provided for the Operating, Tier 1, and Tier 2 Accounts as explained in RFP 21-031, and in making and implementing investment decisions in accordance with the objectives and guidelines specified in CalOptima's Annual Investment Policy. CalOptima hereby appoints CONTRACTOR as its agent and attorney-in-fact with full discretionary authority to buy, sell or otherwise effect investment transactions involving the assets of the Operating, Tier 1, and Tier 2 Accounts in its name, on CalOptima's behalf.

CalOptima hereby authorizes CONTRACTOR to vote any securities held in the Operating, Tier 1, and Tier 2 Accounts in accordance with CONTRACTOR's proxy voting policies in effect from time to time. CalOptima hereby authorizes CONTRACTOR to exercise the rights, options, warrants, conversion privileges, redemption privileges and the tender of securities (collectively, "Corporate Actions") held in the Operating, Tier 1, and Tier 2 Accounts. CalOptima shall cause all proxy, Corporate Action materials and related communications received by it or on its behalf to be delivered to CONTRACTOR on a timely basis. CONTRACTOR will not advise or take any action on behalf of CalOptima or provide advice for any legal proceedings involving securities held in or formerly held in the Operating, Tier 1, and Tier 2 Accounts, including bankruptcies and class actions.

2. Custody

CalOptima has appointed a custodian to hold possession of the assets of the Account and plans to advise the custodian to accept the instructions regarding trades from CONTRACTOR. CONTRACTOR shall not be the custodian.

3. Brokerage

CONTRACTOR may place orders for the execution of transactions with or through brokers, dealers or banks as CONTRACTOR may select (except for itself), and CONTRACTOR is authorized to give such brokers and dealers all instructions that it shall deem appropriate in connection with the actions it is authorized to take as provided herein. CONTRACTOR is authorized to employ such brokers and dealers for the purchase and sale of Operating, Tier 1, and Tier 2 Account assets and, if applicable, to select the brokerage commission rates at which such transactions are affected. CONTRACTOR may give a copy of this Agreement to any broker, dealer or other party to a transaction for the Operating, Tier 1, and Tier 2 Accounts, to CalOptima's custodian as evidence of CONTRACTOR's authority to act for CalOptima. CONTRACTOR shall not be liable for losses incurred by reason of any act or omission on the part of a broker or dealer or the insolvency of a broker dealer.

4. Reports to CalOptima

CONTRACTOR shall send CalOptima an inventory of the investments of the Account as soon as reasonably possible after the end of each month. Copies of the confirmations of transactions executed will be promptly sent to the custodian. CONTRACTOR does not assume responsibility for the accuracy of information furnished by CalOptima or any agent of CalOptima.

5. Communications

Instructions with respect to securities transactions may be given by CalOptima to CONTRACTOR orally, by wire or electronically, and where deemed necessary, may be confirmed in writing as soon as practical. CONTRACTOR shall be fully protected in relying upon any direction in accordance with this section with respect to any instruction, direction or approval of CalOptima.

6. Form ADV

As required by the Advisers Act, CalOptima acknowledges receipt of CONTRACTOR's Form ADV Part 2, or alternate disclosure brochure. Such disclosure document was provided either (i) at least 48 hours prior to entering into this written Agreement or (ii) at the time of entering into this written Agreement with the right to terminate such Agreement, without penalty, within five (5) business days after entering into it by giving written notice of such cancellation to CONTRACTOR.

Exhibit B
PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR firm-fixed fees based on the rates below for fees and expenses in accordance with the provisions of this Exhibit.

B. CONTRACTOR shall invoice CalOptima on a quarterly basis in arrears for its assets under management. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org. Each invoice shall cite Contract No. 21-10211. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed the fee calculations set forth below in Paragraph E, and such fees include all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. This Contract will be paid on an “assets under management’ basis using each month’s average market value. Assets under management shall be derived as the sum of the average market value for each month of the calendar quarter, divided by 3.

Exhibit B-1

Not applicable for this Contract

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Payden & Rygel, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: _____

Print Name: _____

Title: _____

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
21-10211	
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLLA, if necessary*)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only | Authorized for Local Reproduction Standard Form-LLL

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Exhibit F

Not applicable for this Contract

Exhibit G

Not applicable for this Contract

Exhibit H

Not applicable for this Contract

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

Business Entity Type: _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: _____

City:_____ State:_____ Zip:_____

Business Phone:_____ Email: :_____

President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Consider Approval of Modifications to CalOptima Medical Affairs Policies GG.1304, GG.1325, GG.1500 and GG.1508

Contacts

Emily Fonda, M.D., Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, (714) 246-8549

Recommended Actions

Approve recommended modifications to the following existing medical policies in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. Policy GG.1304: Continuity of Care During Health Network or Provider Termination [Medi-Cal]
2. Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services [Medi-Cal]
3. Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers [Medi-Cal, OneCare Connect]
4. Policy GG.1508: Authorization and Processing of Referrals [Medi-Cal, OneCare, OneCare Connect]

Background/Discussion

CalOptima regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations and laws, as well as CalOptima operations.

Below is a description of the impacted policies, followed by a list of substantive changes to each policy, which are reflected in the attached redline. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **Policy GG.1304: Continuity of Care During Health Network or Provider Termination** establishes coverage and continuity of care guidelines for a member who is involuntarily required to change a health network or provider. A member may have a relationship with a health network or provider that changes from a contracted status to a non-contracted status. This policy is focused on member impact from such a change, and how CalOptima or a Health Network ensures a safe transition for the impacted member(s).

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Policy Section	Proposed Change	Rationale	Impact
Glossary	Definition of Covered Service	Added a description to cited references, added Health Homes Program services	Aligns to current practice
Glossary	Definition of Durable Medical Equipment	Updated per DHCS contract	None
Glossary	Added definition for Primary Care Provider	Add	None

2. **Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services** establishes Continuity of Care guidelines and the process to identify newly enrolled Medi-Cal members who transition into CalOptima, or existing members whose Covered Services are transitioned from Medi-Cal Fee-for-Service to CalOptima who have expedited care needs.

Policy Section	Proposed Change	Rationale	Impact
III.D	Added post-partum period	Aligns with current process; Post-partum period is covered under Continuity of Care.	None
III.P.8-9	Removed references to 1) Whole Child Model (WCM) implementation date, 2) Option for requesting continued case management from a Member's CCS Public Health Nurse during the WCM transition, and 3) Continuity of Care rights for Members transitioning from the Pediatric Palliative Care Waiver Program	Outdated references; these requirements were only in effect in 2019.	None
Glossary	Updated definitions	Align with CalOptima master glossary	None

3. **Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers** defines the process by which a provider or practitioner shall obtain authorization for covered services for a CalOptima Direct (COD) or CalOptima Community Network (CCN) member, including prior authorization, concurrent review, and retrospective review. The policy was reorganized and revised. The Department of Health Care Services (DHCS) has approved this policy for the Medi-Cal program

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Policy Section	Proposed Change	Rationale	Impact
II.A	Removed list of services not requiring authorization and added a reference to CalOptima Policy GG.1508: Authorization and Processing of Referrals for such list of services.	Reduces redundancy across policies.	None
II.A	Reinforced conditions under which a provider may request retrospective authorization, including the inability to verify a member's eligibility for OneCare Connect, as applicable.	Aligns with current operations.	None
II.C	Removed language related to emergency inpatient admission notification from the policy and added a reference to CalOptima Policy GG.1508 for notification by hospital of a member's initial emergency encounter.	Reduces redundancy across policies.	None
II.D.6	Included authorization for non-medical transportation, which is addressed in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.	Reduces redundancy across policies.	None
III.A	Included eligibility verification process for OneCare Connect members.	Aligns with current process; Clarifies provider instruction.	None
III.C and IX	Clarified or defined the types of authorizations: Prior Authorization, Concurrent Review, and Retrospective Review	Aligns with current operations; Improves provider references.	None
III.C.2.d	Clarified the process for electronic submission of routine authorization requests (CalOptima Link), including uploading medical documentation by contracted provider	Aligns with current operations.	None

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Policy Section	Proposed Change	Rationale	Impact
III.C.5.a.ii	Clarified request for approval of additional days for urgent concurrent care with prior authorization in place.	Aligns with current operations.	None
III.C.5, III.D.3	Included language related to CalOptima staff assisting hospital with timely discharge planning.	Aligns with current operations.	None
III.D.	Clarified language related to prior authorization requests from non-contracted provider, including for medically necessary post-stabilization services and medically necessary non-urgent care following emergency room exam.	Aligns with current operations.	None
III.E.2	Included language on the processing timeframe for a retrospective request for authorization, with a reference to CalOptima Policy GG.1508.	Reduces redundancy across policies.	None
III.F	Clarified language related to a request to modify an authorization before rendering services.	Aligns with current operations.	None
IV, new attachments	Revised language referring to policy attachments and added the following authorization request forms as attachments: Medi-Cal behavioral health services and OneCare Connect.	Aligns with current operations.	None
IX	Included the following glossary terms: authorized representative, concurrent review, discharge planning, initial emergency encounter, medical necessity, retrospective review and specialist physician.	Ensures defined terms in the policy are included in the glossary with their definitions.	None

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Policy Section	Proposed Change	Rationale	Impact
IX	Updated the definitions for: covered services, health network, and prior authorization.	Ensures policy glossary contains the standard term definition.	None

4. **Policy GG.1508: Authorization and Processing of Referrals** establishes the procedure by which CalOptima and its health networks shall process a request for prior authorization, concurrent review, and retrospective review of covered services for a member. The policy was reorganized and revised. DHCS has approved this policy for the Medi-Cal program.

Policy Section	Proposed Change	Rationale	Impact
I, II.A, III.C, and IX	Clarified or defined the types of authorization requests: prior authorization, concurrent review, and retrospective review.	Aligns with current operations.	None
II.B	Clarified that a OneCare or OneCare Connect member may request approval for services directly from CalOptima or assigned health network, as applicable.	Align with current operations.	None
II.C and Attachments	Included a reference to policy attachments, in which a table of timeframes for OneCare and OneCare Connect decisions and notifications has been added.	Aligns with current operations.	None
II.D	Added language ensuring that decisions related to medical necessity are consistent and based on sound medical evidence, with references to CalOptima Policies, including Policy GG.1535: Utilization Review Criteria and Guidelines.	Aligns with current operations; Reduces redundancy across policies.	None
II.E, III.G.6.b, and III.H.1.b.viii	Included language ensuring compliance with applicable requirements for Whole Child Model Program, including, but not limited to, CCS program guidelines.	Aligns with current operations.	None
II.G	Included language ensuring that no financial incentives are provided to utilization management decision makers to encourage decisions that result in underutilization.	Aligns with current operations	None

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Policy Section	Proposed Change	Rationale	Impact
II.J	Added conditions under which a provider may request retrospective authorization.	Aligns to CalOptima standard.	CalOptima and the Health Networks will apply the same criteria to retrospective authorization requests.
II.L	Added language related to utilization management of hospital services, including a plan health professional or contracting physician available 24 hours a day, 7 days a week to authorize medically necessary post-stabilization services	Aligns with current operations.	None
II.M	Included language that CalOptima will manage authorizations for a OneCare member whose Medicare benefit has been exhausted when the assigned health network is shared risk.	Aligns with current operations.	None
III.A	Updated language for services that are excluded from the prior authorization process.	Aligns with current operations.	None
III.D	Added language related to notification by hospital of a member's initial emergency encounter.	Aligns with current operations.	None
III.E	Added language related to prior authorization requests from non-contracted provider, including for medically necessary post-stabilization services and medically necessary non-urgent care following emergency room exam.	Ensures that existing requirements for non-contracted providers are clear. Aligns with current operations.	None

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Policy Section	Proposed Change	Rationale	Impact
III.H.4.a-d	Revised and included language related to the type of UM staff permitted to approve, deny, modify, or defer authorization requests, including review denials and those who are permitted to supervise utilization review decisions.	Aligns with current operations.	None
III.I.4	Included language related to communications received afterhours.	Standard business practice, except as otherwise provided in the policy	None
IX	Included the following glossary terms: authorized representative, California Children's Services (CCS) Program, CCS-eligible condition, CalOptima Direct, concurrent review, covered services, initial emergency encounter, retrospective review, and Whole-Child Model (WCM). Updated the definitions for: emergency services and prior authorization.	Maintains consistent definitions across policies	None

Fiscal Impact

The recommended action to approve modifications to CalOptima Policies GG.1304, GG.1325, GG.1500 and GG.1508 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, and in the proposed FY 2021-22 Operating Budget slated for Board consideration at its June 3, 2021 meeting.

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1304: Continuity of Care During Health Network or Provider Termination (Redlined and Clean versions)
2. Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services (Redlined and Clean versions)
3. Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers (Redlined and Clean versions)
4. Policy GG.1508: Authorization and Processing of Referrals (Redlined and Clean versions)
5. Department of Health Care Services All Plan Letter (APL) 20-003: Medi-Cal Network Certification Requirements (supersedes APL 19-002)
6. Department of Health Care Services All Plan Letter (APL) 18-023 California Children's Services Whole Child Model Program

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Policy:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination**
Department:	Medical Management
Section:	Case Management
CEO Approval:	/s/
Effective Date:	02/04/2003
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a Member who is involuntarily required to change a Health Network or Provider.

II. POLICY

A. CalOptima or a Health Network shall ensure Continuity of Care for a Member.

B. CalOptima or a Health Network may require a Member to change his or her Health Network or Provider involuntarily due to special circumstances including, but not limited to ~~the termination,~~ suspensions or non-renewal of ~~the Health Network's Contract for~~ a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and exclusion from the Medi-Cal program as effectuated by the Department of Health Care Services (DHCS).

1. CalOptima or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this Policy.

C. Health Networks shall notify CalOptima of Provider terminations, in accordance with CalOptima Policies DD.2012: Member Notification of Change in the Availability or Location of Covered Services, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. CalOptima shall notify the Member of the new Health Network assignment and the option to select a new Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection Process.

E. A Receiving Health Network shall assume full responsibility for a Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.

~~B.~~

~~C.~~A. ~~A Receiving Health Network shall assume full responsibility for a Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.~~

~~D.~~F. In the event of a change of Health Network under Section II.B. of this Policy, a Receiving Health Network shall ensure the provision of Covered Services to an Affected Member without disruption or delay, including, but not limited to:

1. A Member who is in an active treatment plan;

2. A Member who has medical supply or other needs that affect the Member's quality of life or activities of daily living;

3. A Member who is in the process of evaluation for certain services; and

4. A Member who has other medical care needs.

~~E.~~G. In the event that a Member is required to change Health Networks, CalOptima and the Receiving Health Network shall collaborate to coordinate the provision of current and future Covered Services for the Affected Member.

~~F.~~H. To ensure that inappropriate disruptions or delays in Covered Services do not occur during an Affected Member's transition to a Receiving Health Network, CalOptima and the Receiving Health Network shall make Continuity of Care decisions, in accordance with the guidelines set forth in this Policy and based on the potential best medical outcome for the Affected Member.

~~G. For a California Children's Services (CCS) eligible Member transitioning to CalOptima's WCM program who is required to change to a new Health Network, the Receiving Health Network shall ensure the following:~~

~~1. WCM Continuity of Care is available to the CCS-eligible Member in accordance with the requirements of APL 18-023: California Children's Services Whole Child Model and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services, as follows:~~

~~a. Specialized or Customized Durable Medical Equipment (DME);~~

~~a. Continuity of Care for case management with the CCS-eligible Member's existing CCS public health nurse (applicable only to WCM Members who transitioned into CalOptima's WCM program on July 1, 2019); and~~

~~b.~~a. ~~Authorized prescription drugs that is part of the therapy for the CCS-eligible Condition of the CCS-eligible Member.~~

~~2.~~1. ~~The CCS-eligible Member is provided with written notice explaining the Member's right to request an extension of the Continuity of Care period and the WCM appeal process for Continuity of Care limitations, in accordance with CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.~~

~~1. The CCS-eligible Member is allowed to receive services for the Member's CCS-eligible Condition from a CCS Provider outside of the Receiving Health Network for Continuity of~~

~~Care purposes, in accordance with the requirements of Section III.D of this policy, or if there are no CCS Providers that meet the Member's CCS medical needs within the Receiving Health Network's network.~~

~~2. The CCS-eligible Member is permitted through Continuity of Care to continue to receive services from a provider in the Member's previous Health Network, including their assigned primary care provider, for up to twelve (12) months, in accordance with the requirements of APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.~~

~~H. In the event that the guidelines set forth in this Policy do not address an Affected Member's particular continuity of care circumstance or need during the Affected Member's transition from a Health Network, CalOptima's Chief Medical Officer (CMO), or his or her Designee, shall render final determination of a Health Network's decision regarding the authorization of Covered Services.~~

~~E. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with the provisions of this Policy.~~

~~F.~~E. ~~A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.~~

~~I.~~A. ~~CalOptima or a Health Network may require a Member to change his or her Health Network or Provider involuntarily due to special circumstances including, but not limited to, suspensions or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and from the Medi-Cal program as effectuated by DHCS.~~

~~1. CalOptima or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this Policy.~~

~~J. Health Networks shall notify CalOptima of Provider termination, in accordance with CalOptima Policies DD.2012: Member Notification of Change in Availability or Location of Covered Services, EE.1101A: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.~~

III. PROCEDURE

A. Identification of an Affected Member and the Affected Member's Needs

1. CalOptima shall work in collaboration with the terminating Health Network to ensure identification of an Affected Member who is involuntarily required to change Health Networks and identify those Members who are in need of care coordination of Covered Services within a Health Network.

2. CalOptima shall provide a Receiving Health Network with information about an Affected Member's Continuity of Care needs as the information becomes available.

3. A Receiving Health Network shall evaluate an Affected Member's need for Covered Services and ~~may~~ shall authorize appropriate Covered Services for the Affected Member in a timely manner in order to not delay or interrupt the Affected Member's active treatment plan, in accordance with the provisions of this Policy.

B. Notice to Affected Members of Health Network termination

1. CalOptima shall send written notice of Health Network termination to Affected Members no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services.

2. CalOptima shall obtain approval from the DHCS of the written notice prior to sending the notice of Health Network termination to Affected Members.

C. CalOptima and a Health Network shall use the following Continuity of Care guidelines to provide continued Covered Services to an Affected Member so as to not cause an interruption or delay for the Affected Member:

1. A Receiving Health Network shall provide an Affected Member, who satisfies the Continuity of Care requirements set forth in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, with Continuity of Care with an existing out-of-network provider for the remaining duration of the original Continuity of Care period.

2. A Receiving Health Network shall honor an authorization for a Scheduled Elective Surgery for an Affected Member authorized by the terminating Health Network, unless the Receiving Health Network is able to arrange comparable services without delay or interruption to the Affected Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

3. A Receiving Health Network shall allow an Affected Member who is in the course of oncology treatment to continue his or her course of treatment with the Affected Member's existing Provider as set forth below:

   a. The Receiving Health Network shall evaluate an Affected Member's oncology treatment plan and determine whether it is appropriate to transfer the Affected Member's oncology care services safely to another Provider without delay or interruption to the active treatment plan.

   b. If the Receiving Health Network determines that transferring the Affected Member's oncology care to another Provider may potentially result in an adverse medical outcome or detrimentally affect the Affected Member, the Receiving Health Network shall authorize the Affected Member's oncology services under the Affected Member's existing Provider until the active treatment plan is completed.

4. A Receiving Health Network shall allow an Affected Member, who is in the process of a transplant evaluation to complete transplant care services with the Affected Member's existing Provider. Transplant coordination of care for an Affected Member shall be managed~~,~~ in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

5. A Receiving Health Network shall allow an Affected Member, who is receiving acute inpatient services on the effective date of the Receiving Health Network change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

6. A Receiving Health Network shall authorize an Affected Member, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the Receiving Health Network can arrange for the safe transfer of the Affected Member to another acute care facility that can provide comparable services.

7. If it is necessary for an Affected Member to reschedule post-surgical physician visits after the effective date of the Receiving Health Network change, the Receiving Health Network shall authorize the Affected Member's remaining post-surgical visits ~~which~~ that were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and Medical Necessity.

8. A Receiving Health Network shall authorize continued obstetrical services for an Affected Member, including delivery and the immediate postpartum period, with the Affected Member's existing Provider and hospital if the Affected Member is in her second (2nd) or third (3rd) trimester of pregnancy.

9. If an Affected Member is receiving dialysis services, a Receiving Health Network shall authorize continued dialysis services with the Affected Member's existing dialysis center and nephrologist until the Receiving Health Network has evaluated the Affected Member's dialysis treatment plan and arranged for the Affected Member's safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

10. If an Affected Member has a scheduled diagnostic and Ancillary Service on a date after the Affected Member's effective date of the Health Network change, the Receiving Health Network shall authorize the diagnostic or Ancillary Service with the previously scheduled Provider unless the Receiving Health Network is able to arrange comparable services with another Provider without a delay or interruption in service.

11. If an Affected Member receives injectables as part of an active treatment plan, a Receiving Health Network shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the Affected Member's active treatment plan until the Receiving Health Network has re-evaluated the Affected Member's active treatment plan.

12. If an Affected Member receives long term acute care services, a Receiving Health Network shall authorize the long term care acute care services at the Affected Member's existing facility until the Receiving Health Network has re-evaluated the Affected Member and provides for the safe transfer of the Affected Member's care to an alternate facility, with consideration of family or guardian wishes.

13. A Health Network that authorizes the purchase of Durable Medical Equipment (DME) for an Affected Member shall pay for the cost of the DME even if the delivery of the DME occurs after the Affected Member's effective date of the Health Network change.

14. A Receiving Health Network shall continue to provide an Affected Member with the same medical supplies, quantities, or equipment without disruption or delay in services until the Receiving Health Network has evaluated the Affected Member's medical supply needs.

15. If, after consultation with the Receiving Health Network, the CalOptima Chief Medical Officer (CMO~~,~~), or his or her Designee, ~~the CMO~~ determines certain services are required and the Receiving Health Network refuses to provide them, the CMO may authorize these services on behalf of the Receiving Health Network.

16. If a Receiving Health Network modifies, delays, denies, or takes any other action that triggers Aid Paid Pending an appeal, the Receiving Health Network shall follow Member notification requirements and related provisions, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

17. If CalOptima or a Health Network requires a Member to change his or her Provider involuntarily due to suspensions, decertification, or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and decertification from the Medi-Cal program as effectuated by DHCS, CalOptima or a Health Network shall coordinate with the receiving Provider for ongoing services and treatment.

    a. CalOptima or a Health Network shall ensure the terminated, suspended, or decertified Provider does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

    b. CalOptima or a Health Network shall communicate the notification to the Affected Member in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

18. A Receiving Health Network shall pay for the Covered Services furnished to an Affected Member by the Affected Member's existing Provider as authorized by the terminating Health Network to maintain Continuity of Care in accordance with this ~~policy~~Policy. The Receiving Health Network shall pay a Non-Contracted Provider for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima rate.

~~E.~~D. For a California Children's Services (CCS~~-~~)-eligible ~~Member~~ transitioning to CalOptima's WCM program who is required to change to a new Health Network, the following Continuity of Care requirements shall also apply:

1. WCM Continuity of Care is available to the CCS-eligible Member in accordance with the requirements of APL 18-023: California Children's Services Whole Child Model and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services, as follows:

    a. Specialized or Customized Durable Medical Equipment (DME);

    b. Authorized prescription drugs that is part of the therapy for the CCS-eligible Condition of the CCS-eligible Member.

2. The CCS-eligible Member is provided with written notice explaining the Member's right to request an extension of the Continuity of Care period and the WCM appeal process for Continuity of Care limitations, in accordance with CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

3. The CCS-eligible Member is allowed to receive services for the Member's CCS-eligible Condition from a CCS Provider outside of the Receiving Health Network for Continuity of

Care purposes, in accordance with the requirements of this Policy, or if there are no CCS Providers that meet the Member's CCS medical needs within the Receiving Health Network's network.

4. The CCS-eligible Member is permitted through Continuity of Care to continue to receive services from a Provider in the Member's previous Health Network, including their assigned Primary Care Provider, for up to twelve (12) months, in accordance with the requirements of APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

5. The Receiving Health Network shall allow, upon request, the CCS-eligible Member to maintain access to CCS Providers with whom the Member has an existing relationship for up to twelve (12) months, in accordance with Welfare and Institutions Code section 14094.13, under the following conditions:

   a. The CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or the initial assigned Health Network assumed responsibility for the Member's CCS care under the WCM program.

   b. The out-of-network CCS Provider accepts the Receiving Health Network's rate for services offered or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the out-of-network CCS Provider enters into an agreement on an alternative payment methodology mutually agreed to by the out-of-network CCS Provider and the Receiving Health Network.

   c. The Receiving Health Network confirms that the out-of-network CCS Provider meets applicable professional standards, including CCS standards, and has no disqualifying quality of care issues.

   d. The out-of-network CCS Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

   e. The out-of-network CCS Provider provides treatment information to the Receiving Health Network, to the extent authorized by the State and federal patient privacy provisions.

6. The CCS-eligible Member may petition the Receiving Health Network for an extension of the Continuity of Care period. If the Receiving Health Network does not approve the extension, the CCS-eligible Member may appeal this decision in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1510: Appeal Process.

E. In the event that the guidelines set forth in this Policy do not address an Affected Member's particular continuity of care circumstance or need during the Affected Member's transition from a Health Network, CalOptima's CMO or his or her Designee shall render final determination of a Health Network's decision regarding the authorization of Covered Services.

F. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing

Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with the provisions of this Policy.

G. A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~H. CalOptima may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the Health Network fails to comply with the requirements of this Policy.~~

~~I.~~H. ~~CalOptima or a Health Network shall notify an Affected Member of Provider termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.~~

~~J.~~H. CalOptima or a Health Network shall provide continued Covered Services to an Affected Member so as to not cause an interruption or delay using the following continuity of care guidelines:

1. CalOptima or a Health Network shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months except as provided in Section III.D.~~2.~~ of this Policy for Members eligible with the WCM program.

2. CalOptima or a Health Network shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

I. CalOptima or a Health Network shall notify an Affected Member of Provider termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

J. CalOptima may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the Health Network fails to comply with the requirements of this Policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
~~C.~~D. CalOptima Policy DD.2008: Health Network Selection Process
~~D.~~E. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
~~E.~~F. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
~~F.~~G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~G.~~H. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization

~~H.~~I. CalOptima Policy GG.1510: Appeal Process
~~I.~~J. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
~~J.~~K. CalOptima Policy HH.2002Δ: Sanctions
~~K. Department of Health Care Services All Plan Letter (APL) 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications~~
L. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
N. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontract Terminations (supersedes APL 16-001)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/10/2009	Department of Health Care Services (DHCS)
09/11/2013	Department of Health Care Services (DHCS)
10/14/2015	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)
04/22/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
02/04/2003	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	02/06/2020	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	TBD	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
California ~~Children~~Children's Services (CCS) Program ~~(CCS)~~	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically-eligible individuals under the age of twenty-one (2l) years who have CCS-~~eligible~~Eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services-~~eligible~~Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.

Term	Definition
Covered ~~Services~~Service	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	~~Durable~~Medically Necessary medical equipment ~~means equipment~~that is prescribed ~~by a licensed practitioner to meet medical equipment needs of~~for the Member ~~that~~by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall include CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member ~~on behalf of CalOptima, a Physician Medical Group, or a Health Network.~~ .

Term	Definition
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible Conditions.

1

Policy:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	02/04/2003
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a Member who is involuntarily required to change a Health Network or Provider.

II. POLICY

A. CalOptima or a Health Network shall ensure Continuity of Care for a Member.

B. CalOptima or a Health Network may require a Member to change his or her Health Network or Provider involuntarily due to special circumstances including, but not limited to, suspensions or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and exclusion from the Medi-Cal program as effectuated by the Department of Health Care Services (DHCS).

1. CalOptima or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this Policy.

C. Health Networks shall notify CalOptima of Provider terminations, in accordance with CalOptima Policies DD.2012: Member Notification of Change in the Availability or Location of Covered Services, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. CalOptima shall notify the Member of the new Health Network assignment and the option to select a new Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection Process.

E. A Receiving Health Network shall assume full responsibility for a Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.

F. In the event of a change of Health Network under Section II.B. of this Policy, a Receiving Health Network shall ensure the provision of Covered Services to an Affected Member without disruption or delay, including, but not limited to:

1. A Member who is in an active treatment plan;

2. A Member who has medical supply or other needs that affect the Member's quality of life or activities of daily living;

3. A Member who is in the process of evaluation for certain services; and

4. A Member who has other medical care needs.

G. In the event that a Member is required to change Health Networks, CalOptima and the Receiving Health Network shall collaborate to coordinate the provision of current and future Covered Services for the Affected Member.

H. To ensure that inappropriate disruptions or delays in Covered Services do not occur during an Affected Member's transition to a Receiving Health Network, CalOptima and the Receiving Health Network shall make Continuity of Care decisions, in accordance with the guidelines set forth in this Policy and based on the potential best medical outcome for the Affected Member.

III. PROCEDURE

A. Identification of an Affected Member and the Affected Member's Needs

1. CalOptima shall work in collaboration with the terminating Health Network to ensure identification of an Affected Member who is involuntarily required to change Health Networks and identify those Members who are in need of care coordination of Covered Services within a Health Network.

2. CalOptima shall provide a Receiving Health Network with information about an Affected Member's Continuity of Care needs as the information becomes available.

3. A Receiving Health Network shall evaluate an Affected Member's need for Covered Services and shall authorize appropriate Covered Services for the Affected Member in a timely manner in order to not delay or interrupt the Affected Member's active treatment plan, in accordance with the provisions of this Policy.

B. Notice to Affected Members of Health Network termination

1. CalOptima shall send written notice of Health Network termination to Affected Members no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services.

2. CalOptima shall obtain approval from the DHCS of the written notice prior to sending the notice of Health Network termination to Affected Members.

C. CalOptima and a Health Network shall use the following Continuity of Care guidelines to provide continued Covered Services to an Affected Member so as to not cause an interruption or delay for the Affected Member:

1. A Receiving Health Network shall provide an Affected Member, who satisfies the Continuity of Care requirements set forth in CalOptima Policy GG.1325: Continuity of Care for Members

Transitioning into CalOptima Services, with Continuity of Care with an existing out-of-network provider for the remaining duration of the original Continuity of Care period.

2. A Receiving Health Network shall honor an authorization for a Scheduled Elective Surgery for an Affected Member authorized by the terminating Health Network, unless the Receiving Health Network is able to arrange comparable services without delay or interruption to the Affected Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

3. A Receiving Health Network shall allow an Affected Member who is in the course of oncology treatment to continue his or her course of treatment with the Affected Member's existing Provider as set forth below:

   a. The Receiving Health Network shall evaluate an Affected Member's oncology treatment plan and determine whether it is appropriate to transfer the Affected Member's oncology care services safely to another Provider without delay or interruption to the active treatment plan.

   b. If the Receiving Health Network determines that transferring the Affected Member's oncology care to another Provider may potentially result in an adverse medical outcome or detrimentally affect the Affected Member, the Receiving Health Network shall authorize the Affected Member's oncology services under the Affected Member's existing Provider until the active treatment plan is completed.

4. A Receiving Health Network shall allow an Affected Member, who is in the process of a transplant evaluation to complete transplant care services with the Affected Member's existing Provider. Transplant coordination of care for an Affected Member shall be managed in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

5. A Receiving Health Network shall allow an Affected Member, who is receiving acute inpatient services on the effective date of the Receiving Health Network change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

6. A Receiving Health Network shall authorize an Affected Member, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the Receiving Health Network can arrange for the safe transfer of the Affected Member to another acute care facility that can provide comparable services.

7. If it is necessary for an Affected Member to reschedule post-surgical physician visits after the effective date of the Receiving Health Network change, the Receiving Health Network shall authorize the Affected Member's remaining post-surgical visits that were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and Medical Necessity.

8. A Receiving Health Network shall authorize continued obstetrical services for an Affected Member, including delivery and the immediate postpartum period, with the Affected Member's existing Provider and hospital if the Affected Member is in her second (2nd) or third (3rd) trimester of pregnancy.

9. If an Affected Member is receiving dialysis services, a Receiving Health Network shall authorize continued dialysis services with the Affected Member's existing dialysis center and

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nephrologist until the Receiving Health Network has evaluated the Affected Member's dialysis treatment plan and arranged for the Affected Member's safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

10. If an Affected Member has a scheduled diagnostic and Ancillary Service on a date after the Affected Member's effective date of the Health Network change, the Receiving Health Network shall authorize the diagnostic or Ancillary Service with the previously scheduled Provider unless the Receiving Health Network is able to arrange comparable services with another Provider without a delay or interruption in service.

11. If an Affected Member receives injectables as part of an active treatment plan, a Receiving Health Network shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the Affected Member's active treatment plan until the Receiving Health Network has re-evaluated the Affected Member's active treatment plan.

12. If an Affected Member receives long term acute care services, a Receiving Health Network shall authorize the long term care acute care services at the Affected Member's existing facility until the Receiving Health Network has re-evaluated the Affected Member and provides for the safe transfer of the Affected Member's care to an alternate facility, with consideration of family or guardian wishes.

13. A Health Network that authorizes the purchase of Durable Medical Equipment (DME) for an Affected Member shall pay for the cost of the DME even if the delivery of the DME occurs after the Affected Member's effective date of the Health Network change.

14. A Receiving Health Network shall continue to provide an Affected Member with the same medical supplies, quantities, or equipment without disruption or delay in services until the Receiving Health Network has evaluated the Affected Member's medical supply needs.

15. If, after consultation with the Receiving Health Network, the CalOptima Chief Medical Officer (CMO), or his or her Designee, determines certain services are required and the Receiving Health Network refuses to provide them, the CMO may authorize these services on behalf of the Receiving Health Network.

16. If a Receiving Health Network modifies, delays, denies, or takes any other action that triggers Aid Paid Pending an appeal, the Receiving Health Network shall follow Member notification requirements and related provisions, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

17. If CalOptima or a Health Network requires a Member to change his or her Provider involuntarily due to suspensions, decertification, or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and decertification from the Medi-Cal program as effectuated by DHCS, CalOptima or a Health Network shall coordinate with the receiving Provider for ongoing services and treatment.

    a. CalOptima or a Health Network shall ensure the terminated, suspended, or decertified Provider does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

b. CalOptima or a Health Network shall communicate the notification to the Affected Member in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

18. A Receiving Health Network shall pay for the Covered Services furnished to an Affected Member by the Affected Member's existing Provider as authorized by the terminating Health Network to maintain Continuity of Care in accordance with this Policy. The Receiving Health Network shall pay a Non-Contracted Provider for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima rate.

D. For a California Children's Services (CCS)-eligible transitioning to CalOptima's WCM program who is required to change to a new Health Network, the following Continuity of Care requirements shall also apply:

1. WCM Continuity of Care is available to the CCS-eligible Member in accordance with the requirements of APL 18-023: California Children's Services Whole Child Model and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services, as follows:

a. Specialized or Customized Durable Medical Equipment (DME);

b. Authorized prescription drugs that is part of the therapy for the CCS-eligible Condition of the CCS-eligible Member.

2. The CCS-eligible Member is provided with written notice explaining the Member's right to request an extension of the Continuity of Care period and the WCM appeal process for Continuity of Care limitations, in accordance with CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

3. The CCS-eligible Member is allowed to receive services for the Member's CCS-eligible Condition from a CCS Provider outside of the Receiving Health Network for Continuity of Care purposes, in accordance with the requirements of this Policy, or if there are no CCS Providers that meet the Member's CCS medical needs within the Receiving Health Network's network.

4. The CCS-eligible Member is permitted through Continuity of Care to continue to receive services from a Provider in the Member's previous Health Network, including their assigned Primary Care Provider, for up to twelve (12) months, in accordance with the requirements of APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

5. The Receiving Health Network shall allow, upon request, the CCS-eligible Member to maintain access to CCS Providers with whom the Member has an existing relationship for up to twelve (12) months, in accordance with Welfare and Institutions Code section 14094.13, under the following conditions:

a. The CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or the initial assigned Health Network assumed responsibility for the Member's CCS care under the WCM program.

b. The out-of-network CCS Provider accepts the Receiving Health Network's rate for services offered or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the out-of-network CCS Provider enters into an agreement on an alternative payment methodology mutually agreed to by the out-of-network CCS Provider and the Receiving Health Network.

c. The Receiving Health Network confirms that the out-of-network CCS Provider meets applicable professional standards, including CCS standards, and has no disqualifying quality of care issues.

d. The out-of-network CCS Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

e. The out-of-network CCS Provider provides treatment information to the Receiving Health Network, to the extent authorized by the State and federal patient privacy provisions.

6. The CCS-eligible Member may petition the Receiving Health Network for an extension of the Continuity of Care period. If the Receiving Health Network does not approve the extension, the CCS-eligible Member may appeal this decision in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1510: Appeal Process.

E. In the event that the guidelines set forth in this Policy do not address an Affected Member's particular continuity of care circumstance or need during the Affected Member's transition from a Health Network, CalOptima's CMO or his or her Designee shall render final determination of a Health Network's decision regarding the authorization of Covered Services.

F. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with the provisions of this Policy.

G. A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

H. CalOptima or a Health Network shall provide continued Covered Services to an Affected Member so as to not cause an interruption or delay using the following continuity of care guidelines:

1. CalOptima or a Health Network shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months except as provided in Section III.D. of this Policy for Members eligible with the WCM program.

2. CalOptima or a Health Network shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

I. CalOptima or a Health Network shall notify an Affected Member of Provider termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

J. CalOptima may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the Health Network fails to comply with the requirements of this Policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
D. CalOptima Policy DD.2008: Health Network Selection Process
E. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
F. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
H. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
I. CalOptima Policy GG.1510: Appeal Process
J. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Policy HH.2002Δ: Sanctions
L. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
N. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontract Terminations (supersedes APL 16-001)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/10/2009	Department of Health Care Services (DHCS)
09/11/2013	Department of Health Care Services (DHCS)
10/14/2015	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)
04/22/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
02/04/2003	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	02/06/2020	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	TBD	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically-eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall include CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

Term	Definition
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible Conditions.

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Policy:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Management
Section:	Case Management
~~*Interim* ~~*CEO Approval:*	
Effective Date:	01/01/2015
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify ~~Members who have expedited care needs for~~ newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima~~.~~ who have expedited care needs.

II. POLICY

A. ~~Effective July 1, 2017,~~ CalOptima shall screen all ~~new~~newly enrolled Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.~~C~~D. of this Policy, if the ~~following~~ criteria outlined in Section III.C. are met~~:~~.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the CCS Program and transitioned into the WCM program as described in Section III.P.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations, which may allow a Medi-Cal Member a longer period of treatment by an Out-of-Network provider than would be required under DHCS All Plan Letter 18-008 (Revised): Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An Existing Out-of-Network Provider approved to provide continuing treatment must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or the Member's Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a Health Information Form (HIF) in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach, case management, and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1201Δ: Health Education Programs.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

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C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.D. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following:

   a. An ~~out~~Out-of-~~network~~Network Primary Care Practitioner/Physician (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. An ~~out~~Out-of-~~network~~Network California Children's Services (CCS) Provider if the CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or a Health Network assumed responsibility for the Member's CCS care under the Whole Child Model (WCM) program;

   c. An ~~out~~Out-of-~~network~~Network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

   d. An ~~out~~Out-of-~~network~~Network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; or

   e. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept the higher of CalOptima's or a Health Network's rates, the Medi-Cal FFS rates, or the CCS FFS rates (which apply only to the existing out-of-network CCS Provider), as applicable. Notwithstanding the foregoing, the Existing Out-of-Network Provider may enter into an agreement on an alternative payment methodology mutually agreed to by the Existing Out-Of-Network Provider and CalOptima or a Health Network, as applicable.

3. The Existing Out-of-Network Provider meets applicable professional standards, including, as applicable, CCS standards (which apply only to the existing out-of-network CCS Provider providing treatment to a CCS-eligible Member for a CCS-Eligible Condition).

4. The Existing Out-of-Network Provider has no disqualifying quality of care issues. For purposes of this subsection, a quality of care issue means CalOptima or a Health Network can document its concerns with the Existing Out-of-Network Provider's quality of care to the extent the provider would not be eligible to provide services to any other Members of CalOptima or a Health Network.

5. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

6. The Existing Out-of-Network Provider is a California State Plan-approved provider.

7. The Existing Out-of-Network Provider provides CalOptima or a Health Network, with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity~~,~~ as well as a current treatment plan~~,~~ to the extent allowed under federal and state privacy laws and regulations.

8. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

~~D.~~ Upon request from the Member, Member's Authorized Representative, or provider, and in accordance with ~~CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:~~

~~1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the CCS Program and transitioned into the WCM program as described in Section III.O.8.b.i. of this Policy;~~

~~2.~~1. ~~Transportation; and~~

~~3.~~1. ~~Other ancillary services.~~

~~E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal Member a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised): Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care.~~

~~F.~~D. ~~CalOptima or a Health Network shall not provide Continuity of Care for:~~

~~1. Services not covered by Medi-Cal; and~~

~~2.~~1. ~~Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).~~

~~G.~~D. ~~If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:~~

~~1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and~~

~~2.~~1. ~~Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.~~

~~H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.~~

~~I.~~D. ~~CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.~~

~~J.~~D. ~~CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.~~

~~III.~~I. ~~PROCEDURE~~

~~A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.~~

~~1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.~~

~~B.~~A. ~~CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.~~

~~1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population-Based Care: Disease Management.~~

~~2.~~1. ~~Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.~~

~~C.~~D. ~~Upon request from the Member, and in accordance with~~ the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an ~~out~~Out-of-~~network~~Network nursing facility, PCP, Specialty Care Provider, or CCS Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;
2. A serious Chronic Health Condition: Up to twelve (12) months;
3. Pregnancy: For the duration of the pregnancy and post-partum;
4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;
5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;
6. Surgery that is part of a documented course of treatment and has been recommended and documented by the ~~out~~Out-of-~~network~~Network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or
7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

~~D.~~E. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;
2. Authorized Representative of the Member; or

3. Provider.

~~E.~~F. Upon receiving a request for Continuity of Care, CalOptima's Customer Service, Information Services, Utilization Management, and Case Management Departments shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

   a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

   b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section ~~H~~III.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section ~~H~~III.C.1., and include the last date upon which services were provided.

      i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

   c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

~~3.~~1. ~~If DHCS has notified CalOptima of a provider suspension, termination, or decertification, CalOptima or a Health Network shall not approve the Continuity of Care request.~~

~~4.~~3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

~~5.~~4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

~~6.~~5. Refer the case to CalOptima's Case Management Department for access to care issues.

6. If DHCS has notified CalOptima of a provider suspension, termination, or decertification, CalOptima or a Health Network shall not approve the Continuity of Care request.

~~F.~~G. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

~~G.~~H. If the PCP, Specialty Care Provider or other provider specified in this Policy is an ~~out~~Out-of-~~network~~Network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

~~H.~~I. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned to an Existing Out-of-Network Provider in accordance with this Policy.

~~I.~~J. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

~~J.~~K. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this ~~policy~~Policy, risk of harm means an imminent and serious threat to the health of the Member.

~~K.~~L. CalOptima or a Health Network shall notify the Member of the following, in writing, and as required and in accordance with All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised), within seven (7) calendar days of the completion of a Continuity of Care request~~.~~:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

   a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance.

~~L.~~M. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.~~O~~P.8.~~b.iv~~c. for Members in the WCM program.

~~M.~~N. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

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1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

~~N.~~O. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

~~O.~~P. Other Continuity of Care Requirements

1. Former Covered California Enrollees

   a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

   b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

   c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section ~~H~~III.C. of this Policy.

   d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.~~C~~D. of this Policy.

2. Seniors and Persons with Disabilities

   a. CalOptima or a Health Network shall honor, without request by the Member or the Member's ~~out~~Out-of-~~network~~Network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

      i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

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b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section ~~H~~III.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section ~~H~~III.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to ~~out~~Out-of-~~network~~Network providers in accordance with Section ~~H~~III.C. of this Policy for up to twelve (12) months.

6. Skilled Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an ~~out~~Out-of-~~network~~Network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the ~~out~~Out-of-~~network~~Network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima~~,~~ or a Health Network~~,~~ is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for ~~Nursing Facility (NF)~~ nursing facility services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of ~~an NF~~a nursing facility prior to enrollment in CalOptima to change ~~NFs~~nursing facilities during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide ~~continuity~~Continuity of ~~care~~Care with an ~~out~~Out-of-~~network~~Network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. ~~Effective upon the DHCS-approved implementation date, no sooner than July 1, 2019,~~ CalOptima or a Health Network shall provide Continuity of Care rights for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS Provider for up to twelve (12) months in accordance with Section ~~H~~III.C. of this Policy. At its discretion, CalOptima or a Health Network may extend the Continuity of Care period beyond the twelve (12) months.

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b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

~~ii. Case Management~~

~~a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.~~

~~iii.~~ii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS ~~eligible~~Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

c. Appealing Continuity of Care Limitations

i. CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if CalOptima or a Health Network denies the petition. The appeals process notice must include the following information:

a) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: ~~Appeals~~Appeal Process ~~Regarding Care and Services~~; and

b) CalOptima or a Health Network shall inform a Member, during the appeal process, of their right to request a State Hearing after the internal appeal process has been exhausted or should have been exhausted in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

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~~9. Pediatric Palliative Care (PPC) Waiver Transitions~~

~~a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for an eligible Member with his or her Existing Out-of-Network Provider who provided PPC Waiver Program services to the Member for services that are also covered by Medi-Cal under Early and Periodic Screening, Diagnostic and Treatment (ESPDT) in accordance with Section II.C. of this Policy.~~

~~b. CalOptima or a Health Network is not required to provide Continuity of Care for services that were exclusive to the PPC Waiver Program and that are not covered by Medi-Cal under EPSDT.~~

~~P.~~Q. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

~~Q.~~R. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

~~R.~~S. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B.~~A. ~~CalOptima Policy GG.1401: Pharmacy Authorization Process~~
~~C.~~A. ~~CalOptima Policy GG.1508: Authorization and Processing of Referrals~~
~~D. CalOptima Policy HH.1102: CalOptima Member Complaint~~
~~E.~~B. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
C. CalOptima Policy GG.1201Δ: Health Education Programs
~~F.~~D. CalOptima Policy GG.1301: Comprehensive Case Management Process
~~G. CalOptima Policy GG.1209: Population-Based Care: Disease Management~~
~~H.~~E. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
~~I.~~F. CalOptima Policy GG.1330: Case Management – California Children's Services ~~Program~~/Whole Child Model
G. CalOptima Policy GG.1401: Pharmacy Authorization Process
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~J. CalOptima Policy GG.1401: Pharmacy Authorization Process~~
~~K.~~I. CalOptima Policy GG.1510: ~~Appeals~~Appeal Process ~~Regarding Care and Services~~
J. CalOptima Policy HH.1102: Member Grievance
~~L.~~K. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~M.~~L. California Health and Safety Code, §1374.73
~~N.~~M. California Health and Safety Code, §1373.96
~~O.~~N. California Welfare and Institutions Code § 14094.13

~~P.~~O. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect

~~Q.~~P. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)

~~R.~~Q. Department of Health Care Services, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/15/2015	Department of Health Care Services (DHCS)
08/23/2016	Department of Health Care Services (DHCS)
07/11/2017	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)
06/26/2018	Department of Health Care Services (DHCS)
09/20/2018	Department of Health Care Services (DHCS)
10/18/2018	Department of Health Care Services (DHCS)
01/18/2019	Department of Health Care Services (DHCS)
04/14/2020	Department of Health Care Services (DHCS)
03/12/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	02/06/2020	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	TBD	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Treatment (BHT)	~~Professional services and treatment programs, including but not limited to~~Services approved in the State Plan such as Applied Behavior Analysis (ABA) and other evidence-based ~~behavior intervention programs that develop and restore~~behavioral interventions to prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of ~~an individual with ASD. BHT is the design, implementation,~~a Member. These services are interventions designed to treat ASD, and include a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and ~~evaluation of environmental modification using behavioral stimuli~~/or other nationally recognized scientific and ~~consequences to produce socially significant improvement in human behavior~~clinical evidence that are designed to be delivered primarily in the home and in other community settings.
Behavioral Health Treatment (BHT) Service Provider	~~There are three (3) classifications:~~ ~~1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA)~~ ~~2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst)~~ ~~QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.~~Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS)-~~eligible Condition~~Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations Sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS ~~program~~Program to treat a CCS-~~eligible~~Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS ~~program~~Program to treat a CCS-~~eligible~~Eligible Condition; or (3) A special care center approved by the CCS ~~program~~Program to treat a CCS-~~eligible~~Eligible Condition.

Term	Definition
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Existing Out-of-Network Provider	For purposes of this Policy, ~~an~~a non-contracted out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, CCS Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider~~.~~ with whom the Member has established care and continues to be engaged in care at the time of transition to CalOptima services.
Health Risk Assessment (HRA)	A health questionnaire~~,~~ used to provide Members with an evaluation of their health risks and quality of life~~.~~[f].
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary ~~services~~ Covered Services to protect life, to prevent ~~significant~~ illness or ~~significant~~ disability, ~~or to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury~~.~~, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Out-of-Network	For purposes of this policy, a provider that does not participate in CalOptima's or a Health Network's provider network.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. ~~-~~The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~ Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. ~~-~~A PCP may also be a ~~non~~Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a ~~specialist~~specialty care provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. EPSDT supplemental Specialty Mental Health Services.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

Term	Definition
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS ~~program~~Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-~~eligible~~Eligible Conditions.

1

Policy:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	01/01/2015
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima who have expedited care needs.

II. POLICY

A. CalOptima shall screen all newly enrolled Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.D. of this Policy, if the criteria outlined in Section III.C. are met.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the CCS Program and transitioned into the WCM program as described in Section III.P.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations, which may allow a Medi-Cal Member a longer period of treatment by an Out-of-Network

provider than would be required under DHCS All Plan Letter 18-008 (Revised): Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An Existing Out-of-Network Provider approved to provide continuing treatment must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or the Member's Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a Health Information Form (HIF) in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach, case management, and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1201Δ: Health Education Programs.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another

Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.D. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following:

    a. An Out-of-Network Primary Care Practitioner/Physician (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

    b. An Out-of-Network California Children's Services (CCS) Provider if the CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or a Health Network assumed responsibility for the Member's CCS care under the Whole Child Model (WCM) program;

    c. An Out-of-Network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

    d. An Out-of-Network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; or

    e. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept the higher of CalOptima's or a Health Network's rates, the Medi-Cal FFS rates, or the CCS FFS rates (which apply only to the existing out-of-network CCS Provider), as applicable. Notwithstanding the foregoing, the Existing Out-of-Network Provider may enter into an agreement on an alternative payment methodology mutually agreed to by the Existing Out-Of-Network Provider and CalOptima or a Health Network, as applicable.

3. The Existing Out-of-Network Provider meets applicable professional standards, including, as applicable, CCS standards (which apply only to the existing out-of-network CCS Provider providing treatment to a CCS-eligible Member for a CCS-Eligible Condition).

4. The Existing Out-of-Network Provider has no disqualifying quality of care issues. For purposes of this subsection, a quality of care issue means CalOptima or a Health Network can document its concerns with the Existing Out-of-Network Provider's quality of care to the extent the provider would not be eligible to provide services to any other Members of CalOptima or a Health Network.

5. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

6. The Existing Out-of-Network Provider is a California State Plan-approved provider.

7. The Existing Out-of-Network Provider provides CalOptima or a Health Network, with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity as well as a current treatment plan to the extent allowed under federal and state privacy laws and regulations.

8. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. Upon request from the Member, Member's Authorized Representative, or provider, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an Out-of-Network nursing facility, PCP, Specialty Care Provider, or CCS Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy and post-partum;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the Out-of-Network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

E. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

F. Upon receiving a request for Continuity of Care, CalOptima's Customer Service, Information Services, Utilization Management, and Case Management Departments shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

   a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section III.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section III.C.1. and include the last date upon which services were provided.

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

6. If DHCS has notified CalOptima of a provider suspension, termination, or decertification, CalOptima or a Health Network shall not approve the Continuity of Care request.

G. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

H. If the PCP, Specialty Care Provider or other provider specified in this Policy is an Out-of-Network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

I. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned to an Existing Out-of-Network Provider in accordance with this Policy.

J. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

K. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this Policy, risk of harm means an imminent and serious threat to the health of the Member.

L. CalOptima or a Health Network shall notify the Member of the following, in writing, and as required and in accordance with All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who

Transition into Medi-Cal Managed Care (Revised), within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

    a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: Member Grievance.

M. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.P.8.c. for Members in the WCM program.

N. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

O. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

P. Other Continuity of Care Requirements

1. Former Covered California Enrollees

   a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

   b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

   c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section III.C. of this Policy.

   d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.D. of this Policy.

2. Seniors and Persons with Disabilities

   a. CalOptima or a Health Network shall honor, without request by the Member or the Member's Out-of-Network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

      i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

   b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

   a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section III.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

   b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

   a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section III.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to Out-of-Network providers in accordance with Section III.C. of this Policy for up to twelve (12) months.

6. Skilled Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an Out-of-Network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the Out-of-Network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima or a Health Network is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for nursing facility services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of a nursing facility prior to enrollment in CalOptima to change nursing facilities during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide Continuity of Care with an Out-of-Network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. CalOptima or a Health Network shall provide Continuity of Care rights for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS Provider for up to twelve (12) months in accordance with Section III.C. of this Policy. At its discretion, CalOptima or a Health Network may extend the Continuity of Care period beyond the twelve (12) months.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

c. Appealing Continuity of Care Limitations

i. CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if CalOptima or a Health Network denies the petition. The appeals process notice must include the following information:

a) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeal Process; and

b) CalOptima or a Health Network shall inform a Member, during the appeal process, of their right to request a State Hearing after the internal appeal process has been exhausted or should have been exhausted in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

Q. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

R. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

S. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
C. CalOptima Policy GG.1201Δ: Health Education Programs
D. CalOptima Policy GG.1301: Comprehensive Case Management Process
E. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
F. CalOptima Policy GG.1330: Case Management – California Children's Services/Whole Child Model
G. CalOptima Policy GG.1401: Pharmacy Authorization Process
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1108: State Hearing Process and Procedures

L. California Health and Safety Code, §1374.73
M. California Health and Safety Code, §1373.96
N. California Welfare and Institutions Code § 14094.13
O. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
P. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
Q. Department of Health Care Services, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/15/2015	Department of Health Care Services (DHCS)
08/23/2016	Department of Health Care Services (DHCS)
07/11/2017	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)
06/26/2018	Department of Health Care Services (DHCS)
09/20/2018	Department of Health Care Services (DHCS)
10/18/2018	Department of Health Care Services (DHCS)
01/18/2019	Department of Health Care Services (DHCS)
04/14/2020	Department of Health Care Services (DHCS)
03/12/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	02/06/2020	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	TBD	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Treatment (BHT)	Services approved in the State Plan such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions to prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat ASD, and include a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.
Behavioral Health Treatment (BHT) Service Provider	Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS)-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations Sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS Program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS Program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS Program to treat a CCS-Eligible Condition.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Term	Definition
Existing Out-of-Network Provider	For purposes of this Policy, a non-contracted out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, CCS Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider with whom the Member has established care and continues to be engaged in care at the time of transition to CalOptima services.
Health Risk Assessment (HRA)	A health questionnaire used to provide Members with an evaluation of their health risks and quality of life.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Out-of-Network	For purposes of this policy, a provider that does not participate in CalOptima's or a Health Network's provider network.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

Term	Definition
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. EPSDT supplemental Specialty Mental Health Services.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-Eligible Conditions.

1

Policy:	GG.1500
Title:	**Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	02/01/1998
Revised Date:	03/01/2021
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Direct (COD) or CalOptima Community Network (CCN) Member~~.~~, including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner ~~requests authorization~~shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Authorization Required List, available at www.caloptima.org, in accordance with this ~~policy~~Policy, except as provided in ~~Section II.B~~CalOptima Policy GG.1508: Authorization and Processing of ~~this policy, as follows:~~Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and post-stabilization services after an emergency admission, prior to rendering such Covered Services to a Member.

2. A Provider or Practitioner ~~requests~~may request retrospective authorization for Covered Services rendered to a Member as long as such request is made within sixty (60) calendar days after the initial date of service ~~if~~and if one of the following conditions apply:

   a. The Member has Other Health Coverage (OHC); or

   b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare Connect, as applicable, and CalOptima eligibility at the time of service.

3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member who is retroactively eligible for the CalOptima program within one hundred twenty (120) calendar days after the Member's retroactive eligibility determination is available in the State of California Beneficiary Eligibility Verification System.

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~~B. CalOptima does not require a Provider or Practitioner to request authorization for the following Covered Services:~~

~~1. Emergency Services, in accordance with the provisions of this policy. Prior Authorization is not required to screen or stabilize a Member who seeks emergency medical treatment, or where a prudent layperson could reasonably determine that a presenting complaint is an emergency;~~

~~2. Sensitive Services;~~

~~3. Minor Consent Services for Members enrolled in the CalOptima Medi-Cal program;~~

~~4. Family Planning services;~~

~~5. Primary and preventive care services;~~

~~6. Routine obstetric services;~~

~~7. Basic prenatal services;~~

~~8. Sexually Transmitted Disease (STD) services;~~

~~9. HIV testing;~~

~~10. Initial mental health assessment; and~~

~~11. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.~~

~~C.~~B. Contracted and Non-Contracted Emergency Service Providers

1. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on CalOptima.

2. Emergency Services are not subject to Prior Authorization by CalOptima, and CalOptima ~~does~~shall not limit ~~the meaning of~~ what constitutes an Emergency Medical Condition ~~based solely~~ on ~~a list~~the basis of lists of diagnoses or symptoms. CalOptima shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

~~3. Prior Authorization for post-stabilization services and non-urgent care following an exam in an emergency room:~~

~~a. CalOptima approves or denies a request for post-stabilization inpatient services or non-urgent care following an exam in an emergency room made by a non-contracting Provider on behalf of a Member who has received Emergency Services within thirty (30) minutes after receipt of the request. If CalOptima fails to approve or deny an authorization within the required timeframe, the authorization is deemed approved.~~

~~b. Denied/Transfer: In the event that CalOptima denies a request for authorization, and transfers the Member to another Provider, payment is made for Medically Necessary services furnished to the Member to maintain his or her stabilized condition up to the time that it effectuates the Member's transfer at the rate as provided in CalOptima Policy~~

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~~FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.~~

~~c. No Prior Authorization Sought from CalOptima: If a Non-Contracted Provider does not seek authorization for post-stabilization services from CalOptima, then CalOptima is only financially responsible for the Emergency Services, and not for any post-stabilization services.~~

~~d. CalOptima does not hold a Member liable for payment of subsequent screening and treatment required to diagnose a specific condition or stabilization.~~

C. ~~A~~A hospital shall notify CalOptima within twenty-four (24) hours of a Member's Initial Emergency Encounter in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. A Provider or Practitioner ~~obtains~~shall obtain authorization for the following services, in accordance with specified CalOptima policies:

1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in accordance with CalOptima Policy ~~GG.1101: California Children's Services~~CalOptima Policy GG.1508: Authorization and Processing of Referrals;

2. Medical Supplies, in accordance with CalOptima Policies GG.1401: Pharmacy Authorization Process, GG.1508: Authorization and Processing of Referrals, and MA.6101: Coverage Determination;

3. Disposable incontinence supplies, in accordance with CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies;

4. Durable Medical Equipment, in accordance with CalOptima Policy GG.1502: Criteria and Authorization for Durable Medical Equipment, Excluding Wheelchairs;

5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Policy GG.1531: Criteria and Authorization for Wheelchair Rental, Purchase, and Repair;

6. Non-emergency medical transportation and non-medical transportation, in accordance with CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical;

7. Hospice services, in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage and Authorization Requirements;

8. Pharmacy services, in accordance with CalOptima Policies GG.1401: Pharmacy Authorization Process and MA.6101: Coverage Determination; and

~~9.~~ Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with CalOptima Policies GG.1548: Authorization ~~for Applied~~and Monitoring of Behavioral ~~Analysis for Autism Spectrum Disorder~~Health Treatment Services and GG.1549: Authorization for Psychological Testing for Mental Health Conditions.

~~10.~~9.

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E. A Provider or Practitioner may ~~Appeal~~appeal CalOptima's utilization management (UM) decision, in accordance with CalOptima ~~Policy~~ Policies CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, and GG.1510: Appeal Process ~~Decisions Regarding Care and Services.~~ .

F. For services that do not require a Prior Authorization, Providers, including ~~Referral Practitioners~~Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

G. CalOptima and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Policy GG.1532: Over and Under Utilization Monitoring.

H. CalOptima shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. A Provider or Practitioner shall verify ~~the Member's Medi-Cal and CalOptima eligibility, in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification.~~ a Member's eligibility as follows:

1. Medi-Cal and CalOptima eligibility: In accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification; and

2. OneCare Connect: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including ~~Referral Practitioners~~Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations as described in CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~1.~~2. A Provider or Practitioner shall submit a fully completed ~~-~~Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima UM Department by:

a. Mail to: Attention: Utilization Management Department
CalOptima
P.O. Box 11033
Orange, CA 92856;

b. Facsimile at (714) 246-8579; or

c. 1-888-587-8088.

d. A ~~Routine~~contracted Provider may submit a routine, non-urgent authorization request ~~may be submitted~~ online via CalOptima Link. The contracted Provider must upload medical documentation to CalOptima Link to support the Medical Necessity of the requested services.

~~2.~~3. If the request is urgent, the Provider or Practitioner must:

a. Specify that the request is urgent on the ARF and fax to (714) 338-~~3137or~~3137; or

b. Notify the CalOptima UM Department of the urgent request by telephone.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima prior to a Member's admission to inpatient status.

~~3.~~5. A hospital shall notify CalOptima of a Member's authorized inpatient admission within twenty-four (24) hours ~~after~~of the admission.

a. Any review for continuation of previously approved concurrent stay is handled as an urgent concurrent request and processed within twenty-four (24) hours of the receipt of the request. CalOptima may extend the decision timeframe to seventy-two (72) hours for the following reasons:

i. ~~i.~~ The request to extend the urgent concurrent care was not made at least twenty-four (24) hour prior to the expiration of the currently approved days. CalOptima may treat the request as an urgent pre-service decision within a seventy-two (72) hour timeframe.

ii. ~~ii.~~ The request to approve additional days for urgent concurrent care is related to care ~~not previously approved by CalOptima~~with a Prior Authorization in place and there is documentation that CalOptima has made at least one (1) attempt and was unable to obtain the needed clinical information within twenty-four (24) hours of the request.

b. ~~Retroactive~~CalOptima staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Direct Members to the most appropriate level of care following facility discharge.

~~C.~~D. Prior Authorization Request from Non-Contracted Provider

1. Medically Necessary Post-Stabilization Services

a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a completed and signed authorization request form from the facility to CalOptima Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare Connect:

i. Identifying information including: Member name, birthdate, CIN and gender;

ii. Name and role of facility clinician requesting Prior Authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation, to include at a minimum:

a) History and physical;

b) Vital signs;

c) Laboratory and/or radiology results;

d) Any available consultation notes; and

e) Physician progress notes.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

c. For a Member enrolled in the Medi-Cal program, CalOptima shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of a written request that fully complies with Section III.D.1.b. of this policy. If CalOptima fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.D.1.~~b~~c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima may notify the non-contracted Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to

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effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.

ii. In the case where CalOptima denies such request and informs the non-contracted Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

d. For a Member enrolled in the OneCare Connect program, CalOptima shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within sixty (60) minutes after receipt of a written request that fully complies with Section III.D.1.b. of this Policy. If CalOptima does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

e. CalOptima shall pay for Medically Necessary post-stabilization services in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a Member enrolled in Medi-Cal, CalOptima shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. A Provider or Practitioner ~~requests retroactive~~may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima's UM Department:

a. Fully completed ARF;

b. Evidence of OHC payment or denial, if applicable;

c. Facility services:

i. Itemized bill;

ii. History and physical;

iii. Discharge summary;

iv. Progress notes;

v. Physician's orders;

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vi. Operative report;

vii. Emergency Department report, if applicable; and

viii. Outpatient procedure report, if applicable.

d. Outpatient professional services;

e. Diagnosis related to services provided;

f. Current Procedural Technology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes;

g. Medical justification;

h. Progress notes; and

i. Procedure report.

2. CalOptima shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals (Attachment A).

~~D. Emergency inpatient admission notification:~~

~~1. If a Member is admitted to a hospital for Emergency Services, the hospital shall submit an admission face sheet to the CalOptima UM Department, by facsimile, within twenty-four (24) hours after admission.~~

~~2. If COD, including CCN, is responsible for the Member's inpatient admission, CalOptima shall issue an initial notification number, as appropriate, to the hospital within one (1) business day after receipt of all necessary information.~~

~~3. The hospital is responsible for providing the admission notification number to all Medi-Cal, and OneCare Connect professional and ancillary Providers and Practitioners associated with the Member's inpatient admission.~~

~~4. If a Member is admitted to a Non-Contracted hospital for Emergency Services, CalOptima may transfer the Member to a contracted hospital for post-stabilization services.~~

~~E.~~F. A Provider or Practitioner may request to modify an authorization prior to ~~submitting a claim,~~rendering services by contacting the CalOptima UM Department.

~~F.~~G. CalOptima shall process a request for authorization, in accordance with CalOptima Policy ~~GA~~GG.1508: Authorization and Processing of Referrals.

~~G.~~H. CalOptima shall process a request for authorization of ~~Out~~out-of-~~Network~~network and/or ~~Out~~out-of ~~Area~~-area services, in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

IV. ATTACHMENT(S)

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A. CalOptima Authorization Request Form (ARF) – Medi-Cal
B. CalOptima Authorization Request Form (ARF) – Behavioral Health
C. CalOptima Authorization Request Form (ARF) – OneCare Connect

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Payment Disputes
~~B.~~C. CalOptima Health Network Service Agreement
~~C.~~D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
~~D.~~G. CalOptima Policy DD.2003: Verification of Eligibility and Member Identification
~~E.~~H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
~~F.~~I. CalOptima Policy FF.1004: Payment for Hospitals Contracted to Serve CalOptima Direct and CalOptima Community Network Members
~~G.~~J. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
~~H.~~K. CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities
~~I.~~L. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
~~J.~~M. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
~~K.~~N. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~L.~~O. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment, Excluding Wheelchairs
~~M.~~P. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
~~N.~~Q. CalOptima Policy GA.1508: Authorization and Processing of Referrals
~~O.~~R. CalOptima Policy GG.1510: ~~Appeals~~Appeal Process ~~for UM Decisions~~
~~P.~~S. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
~~Q.~~T. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
~~R.~~U. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~S.~~V. CalOptima Policy GG.1548: Authorization ~~for Applied~~and Monitoring of Behavioral ~~Analysis for Autism Spectrum Disorder~~Health Treatment Services
~~T.~~W. CalOptima Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
~~U.~~X. CalOptima Policy MA.6101: Coverage Determination
~~V.~~Y. CalOptima Three-way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
~~W.~~Z. CalOptima Utilization Management Program
~~X.~~AA. Department of Health Care Services All Plan Letter (APL) 17-018: Outpatient Mental Health Services
~~Y.~~BB. Title 22, California Code of Regulations, Section 51003 and 51536
~~Z.~~CC. Title 28, California Code of Regulations, Section 1300.71.4
~~AA.~~DD. Health and Safety Code Sections, 1363.5 and 1367.01
~~BB.~~EE. Title 42, United States Code, Section 139u-2(b)(2)(D)
~~CC.~~FF. Title 42, Code of Federal Regulations, Section 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency
03/10/2016	Department of Health Care Services (DHCS)
04/28/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2009	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	~~01~~10/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g. aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request in dealing with any of the levels of the appeals process.
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CalOptima	For purposes of this policy, CalOptima means CalOptima Direct, including CalOptima Community Network (CCN).
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.

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Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
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Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a ~~health care~~ Provider to obtain advance approval of Covered Services that are Medically Necessary and to ~~provide specific services or procedures~~what amount, duration, and scope, except in the case of an emergency.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

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Policy:	GG.1500
Title:	**Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	02/01/1998
Revised Date:	03/01/2021
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Direct (COD) or CalOptima Community Network (CCN) Member, including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Policy GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and post-stabilization services after an emergency admission, prior to rendering such Covered Services to a Member.

2. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member as long as such request is made within sixty (60) calendar days after the initial date of service and if one of the following conditions apply:

   a. The Member has Other Health Coverage (OHC); or

   b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare Connect, as applicable, and CalOptima eligibility at the time of service.

3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member who is retroactively eligible for the CalOptima program within one hundred twenty (120) calendar days after the Member's retroactive eligibility determination is available in the State of California Beneficiary Eligibility Verification System.

B. Contracted and Non-Contracted Emergency Service Providers

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1. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on CalOptima.

2. Emergency Services are not subject to Prior Authorization by CalOptima, and CalOptima shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. CalOptima shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

C. A hospital shall notify CalOptima within twenty-four (24) hours of a Member's Initial Emergency Encounter in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. A Provider or Practitioner shall obtain authorization for the following services, in accordance with specified CalOptima policies:

1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in accordance with CalOptima Policy CalOptima Policy GG.1508: Authorization and Processing of Referrals;

2. Medical Supplies, in accordance with CalOptima Policies GG.1401: Pharmacy Authorization Process, GG.1508: Authorization and Processing of Referrals, and MA.6101: Coverage Determination;

3. Disposable incontinence supplies, in accordance with CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies;

4. Durable Medical Equipment, in accordance with CalOptima Policy GG.1502: Criteria and Authorization for Durable Medical Equipment, Excluding Wheelchairs;

5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Policy GG.1531: Criteria and Authorization for Wheelchair Rental, Purchase, and Repair;

6. Non-emergency medical transportation and non-medical transportation, in accordance with CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical;

7. Hospice services, in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage and Authorization Requirements;

8. Pharmacy services, in accordance with CalOptima Policies GG.1401: Pharmacy Authorization Process and MA.6101: Coverage Determination; and

9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with CalOptima Policies GG.1548: Authorization and Monitoring of Behavioral Health Treatment Services and GG.1549: Authorization for Psychological Testing for Mental Health Conditions.

E. A Provider or Practitioner may appeal CalOptima's utilization management (UM) decision, in accordance with CalOptima Policies CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, and GG.1510: Appeal Process.

F. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

G. CalOptima and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Policy GG.1532: Over and Under Utilization Monitoring.

H. CalOptima shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member's eligibility as follows:

1. Medi-Cal and CalOptima eligibility: In accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification; and

2. OneCare Connect: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations as described in CalOptima Policy GG.1508: Authorization and Processing of Referrals.

2. A Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima UM Department by:

a. Mail to: Attention: Utilization Management Department
CalOptima
P.O. Box 11033
Orange, CA 92856;

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b. Facsimile at (714) 246-8579; or

c. 1-888-587-8088.

d. A contracted Provider may submit a routine, non-urgent authorization request online via CalOptima Link. The contracted Provider must upload medical documentation to CalOptima Link to support the Medical Necessity of the requested services.

3. If the request is urgent, the Provider or Practitioner must:

a. Specify that the request is urgent on the ARF and fax to (714) 338-3137; or

b. Notify the CalOptima UM Department of the urgent request by telephone.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima prior to a Member's admission to inpatient status.

5. A hospital shall notify CalOptima of a Member's authorized inpatient admission within twenty-four (24) hours of the admission.

a. Any review for continuation of previously approved concurrent stay is handled as an urgent concurrent request and processed within twenty-four (24) hours of the receipt of the request. CalOptima may extend the decision timeframe to seventy-two (72) hours for the following reasons:

i. The request to extend the urgent concurrent care was not made at least twenty-four (24) hour prior to the expiration of the currently approved days. CalOptima may treat the request as an urgent pre-service decision within a seventy-two (72) hour timeframe.

ii. The request to approve additional days for urgent concurrent care is related to care with a Prior Authorization in place and there is documentation that CalOptima has made at least one (1) attempt and was unable to obtain the needed clinical information within twenty-four (24) hours of the request.

b. CalOptima staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Request from Non-Contracted Provider

1. Medically Necessary Post-Stabilization Services

a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a completed and signed authorization request form from the facility to CalOptima Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare Connect:

i. Identifying information including: Member name, birthdate, CIN and gender;

ii. Name and role of facility clinician requesting Prior Authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation, to include at a minimum:

a) History and physical;

b) Vital signs;

c) Laboratory and/or radiology results;

d) Any available consultation notes; and

e) Physician progress notes.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

c. For a Member enrolled in the Medi-Cal program, CalOptima shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of a written request that fully complies with Section III.D.1.b. of this policy. If CalOptima fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima may notify the non-contracted Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.

ii. In the case where CalOptima denies such request and informs the non-contracted Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

d. For a Member enrolled in the OneCare Connect program, CalOptima shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within sixty (60) minutes after receipt of a written request that fully complies with Section III.D.1.b. of this Policy. If CalOptima does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

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e. CalOptima shall pay for Medically Necessary post-stabilization services in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a Member enrolled in Medi-Cal, CalOptima shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima's UM Department:

a. Fully completed ARF;

b. Evidence of OHC payment or denial, if applicable;

c. Facility services:

i. Itemized bill;

ii. History and physical;

iii. Discharge summary;

iv. Progress notes;

v. Physician's orders;

vi. Operative report;

vii. Emergency Department report, if applicable; and

viii. Outpatient procedure report, if applicable.

d. Outpatient professional services;

e. Diagnosis related to services provided;

f. Current Procedural Technology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes;

g. Medical justification;

h. Progress notes; and

i. Procedure report.

2. CalOptima shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals (Attachment A).

F. A Provider or Practitioner may request to modify an authorization prior to rendering services by contacting the CalOptima UM Department.

G. CalOptima shall process a request for authorization, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

H. CalOptima shall process a request for authorization of out-of-network and/or out-of-area services, in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF) – Medi-Cal
B. CalOptima Authorization Request Form (ARF) – Behavioral Health
C. CalOptima Authorization Request Form (ARF) – OneCare Connect

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Payment Disputes
C. CalOptima Health Network Service Agreement
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy DD.2003: Verification of Eligibility and Member Identification
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
I. CalOptima Policy FF.1004: Payment for Hospitals Contracted to Serve CalOptima Direct and CalOptima Community Network Members
J. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
K. CalOptima Policy GG.1113: Specialty Practitioner Responsibilities
L. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
M. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
N. CalOptima Policy GG.1401: Pharmacy Authorization Process
O. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment, Excluding Wheelchairs
P. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
Q. CalOptima Policy GA.1508: Authorization and Processing of Referrals
R. CalOptima Policy GG.1510: Appeal Process

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S. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
T. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
U. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
V. CalOptima Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment Services
W. CalOptima Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
X. CalOptima Policy MA.6101: Coverage Determination
Y. CalOptima Three-way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
Z. CalOptima Utilization Management Program
AA. Department of Health Care Services All Plan Letter (APL) 17-018: Outpatient Mental Health Services
BB. Title 22, California Code of Regulations, Section 51003 and 51536
CC. Title 28, California Code of Regulations, Section 1300.71.4
DD. Health and Safety Code Sections, 1363.5 and 1367.01
EE. Title 42, United States Code, Section 139u-2(b)(2)(D)
FF. Title 42, Code of Federal Regulations, Section 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/10/2016	Department of Health Care Services (DHCS)
04/28/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
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Prior Authorization	A formal process requiring a Provider to obtain advance approval of Covered Services that are Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

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CalOptima
A Public Agency
Better. Together.

P.O. BOX 11033 ORANGE, CA 92856 Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE Fax to (714) 246-8579 ☐ RETRO Fax to (714) 246-8579

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last / First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____ Name of ICF/SNF (if applicable): _____

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____	Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____
Address: Phone: _____ Fax: _____	Address: Phone: _____ Fax: _____
Office Contact: _____ Physician's Signature: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

☐ Inpatient Facility ☐ Outpatient Facility ☐ SNF Estimated Length of Stay: _____

Date(s) of Services: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE — FOR CalOptima USE ONLY

STATUS		Authorization Number #:	
☐ Approved	☐ Alternative Treatment	Signature:	Date:
☐ Not a Covered Benefit	☐ Modified	Comments:	
☐ Not Medically Indicated	Affiliated Health Plan:	Phone:	

Revised 6/12/14

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Medi-Cal

P.O. BOX 11033, ORANGE, CA 92856 **Phone: 855-877-3885**

Behavioral Health Treatment-Authorization Request Form (BHT-ARF)

(This form is for BHT services only)

Behavioral Health Fax: 714-954-2300

***** IN ORDER TO PROCESS YOUR REQUEST, BHT-ARF MUST BE COMPLETE AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

MEMBER INFORMATION			
Member Name (Last, First):		**Sex:** ☐ **M** ☐ **F** ☐ **Other:**	
Age:	**DOB:**	**Client Index # (CIN):**	**ICD-10 Dx:**
Mailing Address:		**Phone:**	

PROVIDER INFORMATION			
ABA Provider:			
Provider NPI:	**TIN:**	**Medi-Cal ID:**	
Address:	**Phone:**	**Fax:**	
Office Contact:	**Provider's Signature:**		

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS Code(s). Supporting documentation to include:

- Functional Behavior Assessment Report
- Treatment Plan/Progress Report
- Developmental and Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

REQUESTED PROCEDURES	HCPCS CODE	UNITS AND DURATION (typically 6 months)
Mental health assessment by non-physician	H0031	
Mental health service plan development by non-physician (Non-BCBA)	H0032-HN	
Mental health service plan development by non-physician (BCBA)	H0032-HO	
Skills training and development	H2014	
Therapeutic behavioral services	H2019	
Home care training to home care client	S5108	
Home care training, family	S5110	
Other		

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OneCare Connect
CalOptima
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Cal MediConnect Plan (Medicare-Medicaid Plan)

P.O. BOX 11033 ORANGE, CA 92856 **Phone: 714- 246-8686**

AUTHORIZATION REQUEST FORM (ARF)

☐ **ROUTINE** ☐ **RETRO** **OneCare Connect Fax 714-571-2440**

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETE AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ **M** ☐ **F** **D.O.B.** _____ **Age:** _____
Last First

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#: _____ **TIN#:** _____ **Medi-Cal ID#:** _____	**Provider NPI#:** _____ **TIN#:** _____ **Medi-Cal ID#:** _____
Address: **Phone:** _____ **Fax:** _____	**Address:** **Phone:** _____ **Fax:** _____
Office Contact: _____ **Physician's Signature:** _____	**Office Contact:** _____
Diagnosis: _____	**ICD-10:** _____

AUTHORIZATION REQUEST

☐ **URGENT REQUEST Fax to 714-571-2440. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.*****

☐ **Inpatient Facility** ☐ **Outpatient Facility** ☐ **SNF:**

Retro Date(s) of Service _____

List ALL procedures requested along with the appropriate CPT/HCPCS and Supporting Documentation

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

Revised 2/15/2017

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Policy:	GG.1508
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	12/01/2017
Revised Date:	03/01/2021
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the procedure by which CalOptima and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this ~~policy~~Policy. CalOptima and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

~~B. General Standards~~

~~a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima identification card, or shall perform an eligibility verification using CalOptima's Provider Portal at www.caloptima.org.~~

~~1. Prior Authorization does not guarantee eligibility at the time services are rendered.~~

B. For ~~Medi-Cal~~ Members~~,~~ enrolled in OneCare or OneCare Connect, CalOptima or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a OneCare or OneCare Connect Health Network Member calls CalOptima before contacting the ~~Provider or Practitioner~~ Health Network regarding an authorization, CalOptima shall ~~verify eligibility at the time~~ transfer such calls to the appropriate Health Network Customer Service line for assistance.

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C. CalOptima and its Health Networks shall follow the ~~service is provided~~applicable Timeframes for Decisions and Notifications Table, as set forth in Attachments A and B of this Policy, for all requested services, whether in- or out-of-network.

~~B.~~D. CalOptima and its Health Networks shall ensure that decisions related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima ~~Policy DD.2003: Member Identification and Eligibility Verification~~Policies GG.1535: Utilization Review Criteria and Guidelines and GG.1541: Utilization Management Delegation.

~~If~~

E. With respect to the Whole Child Model (WCM) program, CalOptima ~~or a~~and its Health ~~Network does~~Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not ~~take action~~limited to, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the Health Networks shall:

1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by ~~approving, denying, deferring,~~their respective medical director or ~~modifying~~the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

F. CalOptima and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services~~,~~ and benefits.

G. CalOptima and the Health Networks shall make utilization management (UM) decisions based only on ~~a written~~appropriateness of care and service, and existence of coverage. CalOptima and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima and the Health Networks do not provide financial incentives to utilization management decision-makers to encourage decisions that result in underutilization.

H. CalOptima and the Health Networks shall not require a Provider or Practitioner to request ~~for~~ Prior Authorization ~~of~~for Covered Services ~~within fourteen (14) calendar days after receipt,~~specified in Section III.A. of this ~~p~~Policy.

~~C.~~I. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such ~~request~~ Provider is unavailable in-network. Referrals to an out-of-network Provider shall be ~~deemed denied by default and a notification of denial for the requested service is sent to the Provider and Member~~ processed in accordance with CalOptima Policy GG.~~1507: Notification Requirements for Covered Services Requiring Prior~~1539: Authorization~~.~~ for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

For Health Network Members,

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2. ~~An Urgent Authorization Request may be submitted if~~ a ~~normal~~Provider, including a Specialist Physician, shall follow the Health Network's authorization ~~timeframe will be detrimental~~process.

J. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a ~~Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function;~~ Member as long as such request is ~~required to be addressed~~made within ~~seventy-two (72) hours or as soon as~~ sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or

2. The Member's ~~health~~medical condition ~~requires~~is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, OneCare, or OneCare Connect program, as applicable, at the time of service.

K. ~~CalOptima and its contracted~~ CalOptima and a Health Network shall ensure that all contracted Providers and non-contracting Specialist Physicians and Providers are informed of the Prior Authorization and Referral process at the time of Referral.

L. CalOptima and its Health Networks that are responsible for utilization management of hospital services shall have a plan health professional or a contracting physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary post-stabilization services, to coordinate the transfer of stabilized Members in an emergency department~~,~~ if necessary, and for general communication with emergency room personnel.

M. If a Member exhausts his or her Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima shall authorize Covered Services in accordance with this Policy or other applicable CalOptima policies and procedures.

~~D.~~N. CalOptima and its Health Networks shall maintain a system for tracking and monitoring all ~~referrals~~Referrals for Provider and Member-requested (OneCare and OneCare Connect Members only) health care services and supplies~~. For Medi-Cal Covered Services, the system, at a minimum, must track~~ requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

~~1. Referral turnaround time for issuing a determination;~~

2. Criteria used in making the determination~~.~~;

~~2.~~3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and

~~3.~~4. Specific services and supplies approved, denied, deferred, or modified.

III. PROCEDURE

~~i. Only a qualified, licensed physician shall review and issue denials of a request for healthcare services for Medical Necessity or benefit coverage related to a Member's medical benefits.~~

2. Only a qualified, licensed clinical psychologist or Board-Certified psychiatrist shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits.

3. Only a qualified, licensed clinical pharmacist shall review and issue denials of a pharmaceutical for Medical Necessity or benefit coverage related to a Member's pharmacy benefits.

C. A Practitioner or Provider shall request Prior Authorization for services and/or supplies for a CalOptima Member, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

D. A Practitioner or Provider shall request Prior Authorization for services for a Health Network Member, in accordance with the Health Network's authorization policy.

A. Services Excluded from the Prior Authorization Process

1. CalOptima and its Health Networks shall not require notification for emergency For the Medi-Cal, OneCare and OneCare Connect programs, the following services and doesdo not require Prior Authorization:

a. Emergency Services or emergency care

i. CalOptima and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. CalOptima and its Health Networks shall not refuse to cover Emergency Services based on the emergency room Provider, or hospital or fiscal agent not notifying the Member's Primary Care Provider (PCP) or CalOptima of the Member's screening and treatment.

ii. CalOptima and its Health Networks shall not require Prior Authorization for emergency care, followingfollow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint ismight be an emergency.

1. Family Planning Services

b. The following Preventive and primary care services;

c. Basic prenatal care;

a.d. Family Planning Services provided to a Member of childbearing age involving delaying or preventing pregnancy do not require Prior Authorization:

i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;

ii. Limited history and physical examination for family planning services;

iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;

iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;

v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and ~~referral~~Referral for treatment;

vii. Provision of contraceptive pills, devices, and supplies;

vi. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;

viii. Tubal ligation~~;~~.

ix. Vasectomies; and

x. Pregnancy testing and counseling.

~~5. Preventative and primary care services;~~

~~b.~~e. Routine obstetrical services; and

f. Elective abortions~~.~~.

2. For the OneCare and OneCare Connect programs, in addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization~~, but must be~~:

a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;

b. Urgent Care sought outside of the service area of Orange County, California;

~~a.~~c. Urgent Care under unusual and extraordinary circumstances provided~~, as follows, to ensure that the Member~~ in the service area of Orange County, California when the contracted medical provider is ~~treated by a qualified Provider:~~unavailable or inaccessible; and

d. ~~A Member shall obtain elective abortion~~Out-of-area renal dialysis services ~~from any~~.

3. For the Medi-Cal ~~licensed Practitioner;~~ Program, in addition to the services identified in Section III.A.1. of this policy, the following services do not require Prior Authorization:

~~a. A Member requesting an elective abortion may access information about qualified Practitioners by calling CalOptima's Customer Service Department or the Member's Health Network Member services department.~~

~~6.~~ Minor Consent Services ~~in the Medi-Cal program~~

a. : The following Minor Consent Services provided to a CalOptima Medi-Cal Member less than eighteen (18) years of age do not require parental consent or Prior Authorization. Minor Consent Services are Covered Services of a sensitive nature related to:

i. Sexual assault, including rape;

ii. Drug or alcohol abuse for a Member twelve (12) years of age or older;

iii. Pregnancy;

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iv. Family Planning, including termination of pregnancy; and

~~ii.~~i. Sexually transmitted diseases (STDs) or HIV/AIDS for a Member twelve (12) years of age or older.

b. Initial mental health ~~assessment~~assessments; and

c. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

~~F. For services that do not require a Prior Authorization, Providers, including Referral Practitioners, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network, in accordance with GG.1539: Authorization for Out-of-Network and Out-of-Area Services.~~

B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1.A

~~1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.~~

~~1. For Health Network Members, a Provider, including Referral Practitioners, shall follow the Health Network's authorization process.~~

~~The~~ PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergency and urgent questions from the Member~~.~~ in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member, and direct the Member to the most appropriate level of service based on the Member's condition.

2. All services shall be provided in the manner and time frames set forth in CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima identification card, or shall perform an eligibility verification using CalOptima's Provider Portal at www.caloptima.org.

b. Prior Authorization does not guarantee eligibility at the time services are rendered.~~Responsibility~~

c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Direct Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

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b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.J. of this Policy.

2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.J. of this policy.

3. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be addressed within seventy-two (72) hours or as soon as the Member's health condition requires.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima or a Health Network, as applicable, prior to a Member's admission to inpatient status.

5. All CalOptima and Health Network authorization requests must include the clinical records that validate the need for the requested item or service.

D. Hospital~~/Provider when~~ Notification of Emergency Services ~~includes Admission for Continuing Treatment~~

~~1. CalOptima Member~~

~~a. The Hospital/Provider shall admit the Member to an approved Provider or Specialist Practitioner and~~ 1. A hospital shall notify CalOptima ~~within twenty-four (24) hours, or the next business day, after the hospital admission by telephone or facsimile.~~

~~b. CalOptima shall issue a tracking number, if medically indicated, after the initial admission review, which will occur~~or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification~~.~~

~~CalOptima shall~~ system is implemented, hospital shall use its best efforts to provide ~~subsequent concurrent review as medically indicated using evidence-based criteria. UM shall complete the concurrent review at a minimum, every three (3) calendar days. If the third day falls on a weekend or holiday, UM shall complete the concurrent review on the next business day. Should Medical Necessity review criteria recommend review more frequently than every three (3) calendar days, subsequent concurrent review will be performed as recommended, utilizing criteria. Authorization is granted based on Medical Necessity met or physician review and agreement~~such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services.

2. ~~CalOptima shall coordinate~~If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima or the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence.

E. Prior Authorization Request from Non-Contracted Provider

1. Medically Necessary Post-Stabilization Services

a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve or resolve the Member's stabilized medical condition.

b. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a completed and signed authorization request form from the facility to CalOptima or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare and OneCare Connect:

i. Identifying information including: Member name, birthdate, CIN and gender;

ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation to include at a minimum:

a) History and physical;

b) Vital signs; and

c) Laboratory and/or radiology results.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

c. For a CalOptima Direct Member enrolled in the Medi-Cal or OneCare Connect program, CalOptima shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary post-stabilization services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

d. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of a written request that fully

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complies with Section III.E.1.b. of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the non-contracted Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii. In the case where the Health Network denies such request and informs the non-contracted Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

e. For a Health Network Member enrolled in the OneCare or OneCare Connect program, a Health Network shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within sixty (60) minutes after receipt of a written request that fully complies with Section III.E.1.b. of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a CalOptima Direct Member enrolled in the Medi-Cal program, CalOptima shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. Health Network staff shall assist the hospital with timely Discharge Planning~~, so that the Member's anticipated needs are met, and discharge plan is continued to the next~~ to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

~~2. Health Network Member~~

~~1. The Hospital/Provider shall notify the Member's Health Network or PCP in accordance with Health Network's policy.~~

~~2. The Hospital/Provider shall admit the Member to the appropriate Provider or Specialist Practitioner, based on the instructions from the Member's Health Network.~~

~~3. Health Network staff shall coordinate timely Discharge Planning so that the Member's anticipated needs are met, and discharge plan is continued to the next appropriate level of care following facility discharge in accordance with Health Network 's policy~~

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.

2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's Customer Service Department (714-246-8500 or toll-free at 888-587-8088/TDD/TTY: 1-800-735-2929), or the Member's Health Network.

3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734/TDD/TTY: 1-800-735-2929), or the Member's Health Network~~;~~.

4. For OneCare Connect, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's OneCare Connect Customer Service Department (toll-free 1-855-705-8823 or TDD/TTY: 1-800-735-2929), or Member's Health Network.

5. CalOptima or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

6. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.

7. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima or the Health Network is unable to provide services within the network, in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

2. CalOptima or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima or the Health Network is unable to provide the services within the network. CalOptima or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima along with medical justification sufficient to make a determination and the physician signature. CalOptima shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.

4. CalOptima or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

5. CalOptima or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Policy EE.1141: CalOptima Provider Contracts.

6. CalOptima or a Health Network shall provide continued access as follows:

   a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship, if there are no quality ~~–~~ of ~~–~~ care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Policy GG.1325: ~~Coordination~~Continuity of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services.

   b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, GG.1401: Pharmacy Authorization Process, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

   ~~b.~~c. For newly enrolled OneCare Connect beneficiaries~~`~~,, for up to twelve (12) months for Medi-Cal and Medicare Covered Services, to an out-of-network Provider with whom the Member has had an ongoing relationship, if there are no quality ~~–~~ of ~~–~~ care issues with the Provider and the Provider accepts contracted or Medi-Cal or Medicare rates, in accordance with CalOptima Policy CMC.6021a: Continuity of Care for New Members.

H. Denials, Deferrals, and Modifications of Prior Authorization Requests

~~2.~~1. Preferred Network Specialist ~~Physician~~. CalOptima or a Health Network may redirect specialty care Prior Authorization requests to a preferred network Specialist Physician under the following conditions:

   a. All modification, denial, and notification requirements are followed pursuant to regulation requirements; and

   b. The preferred Specialist Physician is selected based on the following:

      i. A demonstrated ability to provide the services requested;

      ii. Prolific experience providing the services requested;

      iii. Volume of the requested care previously provided;

      iv. An existing relationship with CalOptima or the Health Network, as applicable;

      v. A proven ability to maintain adequate Member access;

      vi. A proven ability to provide care coordination; ~~and~~

      vii. No existing issues related to continuity of care or Tertiary service needs~~.~~; and

viii. For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist.

~~c.~~a. CalOptima may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

i. A CalOptima Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager~~,~~ or Designee~~,~~ for appropriateness;

ii. The Prior Authorization manager~~,~~ or Designee~~,~~ shall forward the request to a contracted external review agency electronically for review; and

iii. Upon receipt of the recommendation of the external review agency, the CalOptima Medical Director shall conduct the final review and determination.

~~d.~~b. The Quality Improvement (QI) Department shall maintain a list of Board-Certified specialists, and the list will be reviewed annually by the Quality Improvement Committee (QIC).

~~e. CalOptima shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage.~~

~~f. CalOptima does not specifically reward Practitioners or other individuals for issuing denial of coverage or care.~~

3. Tertiary Care.

a. CalOptima or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.

b. CalOptima shall only authorize Tertiary Care services under the following circumstances:

i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;

ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;

iv. A Member or Provider ~~wishes to refer~~requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima; and

v. There is no quality ~~-~~of~~-~~care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed health professional;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.

c. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

i. Only a qualified, licensed physician shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity.

ii. Only a qualified, licensed clinical psychologist or Board-Certified psychiatrist shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and

iii. Only a qualified, licensed ~~In the event a~~physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

5. Notification of UM Decision

a. CalOptima and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare and OneCare Connect, CalOptima and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Policy MA.6042: Organization Determinations.

~~g.~~b. If Medical Necessity criteria are not met, and review by a CalOptima or Health Network physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

~~L. CalOptima shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.~~

~~III.~~I. ~~PROCEDURE~~

c. For routine (non-urgent) authorization requests, if CalOptima or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima UM ~~staff~~Staff and ~~services~~Services

1. CalOptima's UM Department shall provide Members or potential Members access to information, about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, OneCare Evidence of Coverage, and OneCare Connect Member Handbook available in-print and on the CalOptima website at www.caloptima.org.

2. CalOptima's UM Department shall provide Practitioners access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima website at www.caloptima.org.

3. UM staff shall be available for inbound calls regarding UM issues during CalOptima normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima's Customer Service Department~~,~~ and routed to appropriate UM staff.

   a. UM staff shall provide a toll-free number (888-587-8088) and accept collect calls regarding UM issues and will also accept calls at 714-246-8500.

   b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

   c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

   d. UM staff shall be accessible to callers who have questions about the UM process.

   e. UM physicians shall be available to answer denial determination ~~question~~questions during normal business hours and after hours at 888-587-8088 and accept collect calls regarding UM issues and will also accept calls at 714-246-8500. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

   f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service~~. On-call service includes:~~, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next

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business day. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima ~~policies~~Policies DD.2002: Cultural and Linguistic and Services, MA.4002: Cultural and Linguistic and Services, and CMC.4002: Cultural and Linguistic and Services (CalOptima is able to receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima shall provide language assistance services free of charge to Members. CalOptima shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Policies DD.2002: Cultural and Linguistic Services, MA.4002: Cultural and Linguistic and Services, and CMC.4002: Cultural and Linguistic and Services.

7. CalOptima shall send a CalOptima Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Policy DD.2005: Member Handbook Requirements. The handbook will note availability of UM staff in regard to UM issues~~,~~ and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima shall inform Medi-Cal Members of the availability of the CalOptima Member Handbook/Evidence of Coverage.

9. Annually, CalOptima shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members, and the Member Handbook, for OneCare Connect Members.

J. Failure of a Health Network or CalOptima department to comply with CalOptima's authorization ~~process~~policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima's authorization process and reports to the Utilization Management Committee (UMC), Audit & Oversight Committee (AOC), and/or the Compliance Committee~~.~~.

1. Continued non-compliance may lead to issuance of a Corrective Action Plan (CAP) and/or ~~Sanction~~Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Timeframes for Medi-Cal Services Decisions and Notifications
B. Timeframes for OneCare and OneCare Connect Service Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
C. CalOptima Contract with the Centers for ~~Health Care Services~~Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

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~~B.~~E.CalOptima Health Network Service Agreement
~~C.~~F.CalOptima Policy CMC.4002: Cultural and Linguistic and Services
~~D.~~G.CalOptima Policy CMC.6021a: Continuity of Care for New Members
~~E.~~H.CalOptima Policy DD.2003: Member Identification and Eligibility Verification
~~F.~~I. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~G.~~J.CalOptima Policy DD.2005: Member Handbook Requirements
~~H.~~K.CalOptima Policy EE.1141: CalOptima Provider Contracts
L. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
~~I.~~M.CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
~~J.~~N.CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities
~~K.~~O.CalOptima Policy GG.1325: ~~Coordination~~Continuity of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services
P. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
Q. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~L.~~R.CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~M.~~S.CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~N.~~T.CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~O.~~U.CalOptima Policy HH.2002Δ: Sanctions
~~P.~~V.CalOptima Policy HH.2005Δ: Corrective Action Plan
~~Q.~~W.CalOptima Policy MA.4002: Cultural and Linguistic and Services
~~R.~~X.CalOptima Utilization Management Program
Y. Department of Health Care Services All Plan Letter (APL) 18-023 California Children's Services Whole Child Model Program
~~S.~~Z.Department of Health Care Services All Plan Letter (APL) 17-018: Outpatient Mental Health Services
AA. Department of Health Care Services All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~T.~~BB.Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 16-002 (supersedes DPL 15-003): Continuity of Care-Revised 07/05/16
~~U.~~CC.California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
~~V.~~DD.Health and Safety Code, Sections 1363.5 and 1367.01
~~W.~~EE.Medi-Cal Member Handbook
~~X.~~FF.OneCare Evidence of Coverage
~~Y.~~GG.OneCare Connect Member Handbook
~~Z.~~HH.Title 28, California Code of Regulations (CCR), §1300.71.4
II. Title 42, Code of Federal Regulations (CFR), §§ 422.113(c), 438.114 (a), 438.404(c)(5), and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/02/2009	Department of Health Care Services (DHCS)
02/24/2013	Department of Health Care Services (DHCS)
07/11/2014	Department of Health Care Services (DHCS)
08/17/2015	Department of Health Care Services (DHCS)
06/26/2018	Department of Health Care Services (DHCS)
04/19/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	~~For purposes of this policy,~~A direct health care program operated by ~~CalOptima shall include CalOptima Direct~~that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN)~~.~~) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Comprehensive Diagnostic Evaluation~~CalOptima~~	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.~~For purposes of this policy, CalOptima shall include CalOptima Direct and CalOptima Community Network (CCN).~~

Term	Definition
Concurrent Review~~Comprehensive Diagnostic Evaluation~~	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.~~A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.~~
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Term	Definition
Emergency Medical Condition~~Discharge Planning~~	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; ~~1.~~ Serious impairment to bodily functions; or 2. ~~2.~~3. Serious dysfunction of any bodily organ or part.~~Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.~~
Emergency Services~~Emergency Medical Condition~~	Inpatient and outpatient Covered Services furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~ ~~3. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy;~~ ~~4. Serious impairment to bodily functions; or~~ ~~Serious dysfunction of any bodily organ or part.~~
Health Network~~Emergency Services~~	~~For purposes of this policy, a~~A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~
Initial Emergency Encounter ~~Health Network~~	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first. ~~For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Organization Determination~~Medically Necessary or Medical Necessity~~	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.~~Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.~~
Practitioner~~Organization Determination~~	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.~~Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.~~
Prior Authorization~~Practitioner~~	A formal process requiring a health care Provider to obtain advance approval of Covered Services that are Medically Necessary, and to ~~provide specific services or procedures~~what amount, duration, and scope, except in the case of an emergency.~~A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.~~
Provider~~Prior Authorization~~	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.~~
Prudent Layperson~~Provider~~	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation. ~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~

Term	Definition
Referral~~Prudent Layperson~~~~Provider~~	The process of a Provider directing a Member to another Provider for care and /or services. A referral ~~Referral~~ may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider. ~~A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Retrospective Review~~Referral~~~~Prudent Layperson~~	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.~~The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider. A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.~~
Sensitive Services~~Referral~~	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.~~The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.~~
Specialist Physician ~~Sensitive Services~~	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP. ~~Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.~~
Tertiary Care~~Specialist Physician~~~~Sensitive Services~~	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon ~~referral~~Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting. ~~A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.~~
Urgent Authorization Request~~Tertiary Care~~~~Specialist Physician~~	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.~~Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.~~

Term	Definition
Whole-Child Model (WCM) ~~Urgent Authorization RequestTertiary CareSpecialist Physician~~	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. ~~An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.~~
~~Urgent Authorization RequestTertiary Care~~	~~An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.~~
~~Urgent Authorization Request~~	~~An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.~~

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Policy:	GG.1508
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	12/01/2017
Revised Date:	03/01/2021
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the procedure by which CalOptima and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

B. For Members enrolled in OneCare or OneCare Connect, CalOptima or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a OneCare or OneCare Connect Health Network Member calls CalOptima before contacting the Health Network regarding an authorization, CalOptima shall transfer such calls to the appropriate Health Network Customer Service line for assistance.

C. CalOptima and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications Table, as set forth in Attachments A and B of this Policy, for all requested services, whether in- or out-of-network.

D. CalOptima and its Health Networks shall ensure that decisions related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Policies GG.1535: Utilization Review Criteria and Guidelines and GG.1541: Utilization Management Delegation.

E. With respect to the Whole Child Model (WCM) program, CalOptima and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All

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Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the Health Networks shall:

1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

F. CalOptima and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

G. CalOptima and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima and the Health Networks do not provide financial incentives to utilization management decision-makers to encourage decisions that result in underutilization.

H. CalOptima and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.

I. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.

J. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member as long as such request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or

2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, OneCare, or OneCare Connect program, as applicable, at the time of service.

K. CalOptima and a Health Network shall ensure that all contracted Providers and non-contracting Specialist Physicians and Providers are informed of the Prior Authorization and Referral process at the time of Referral.

L. CalOptima and its Health Networks that are responsible for utilization management of hospital services shall have a plan health professional or a contracting physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary post-stabilization services, to

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coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

M. If a Member exhausts his or her Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima shall authorize Covered Services in accordance with this Policy or other applicable CalOptima policies and procedures.

N. CalOptima and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested (OneCare and OneCare Connect Members only) health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

2. Criteria used in making the determination;

3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and

4. Specific services and supplies approved, denied, deferred, or modified.

III. PROCEDURE

A. Services Excluded from the Prior Authorization Process

1. For the Medi-Cal, OneCare and OneCare Connect programs, the following services do not require Prior Authorization:

a. Emergency Services or emergency care

i. CalOptima and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

ii. CalOptima and its Health Networks shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

b. Preventive and primary care services;

c. Basic prenatal care;

d. Family Planning Services:

i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;

ii. Limited history and physical examination for family planning services;

iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;

iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;

v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and Referral for treatment;

vii. Provision of contraceptive pills, devices, and supplies;

vi. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;

viii. Tubal ligation.

ix. Vasectomies; and

x. Pregnancy testing and counseling.

e. Routine obstetrical services; and

f. Elective abortions.

2. For the OneCare and OneCare Connect programs, in addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization:

a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;

b. Urgent Care sought outside of the service area of Orange County, California;

c. Urgent Care under unusual and extraordinary circumstances provided in the service area of Orange County, California when the contracted medical provider is unavailable or inaccessible; and

d. Out-of-area renal dialysis services.

3. For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this policy, the following services do not require Prior Authorization:

a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima Medi-Cal Member less than eighteen (18) years of age do not require parental consent or Prior Authorization. Minor Consent Services are Covered Services of a sensitive nature related to:

i. Sexual assault, including rape;

ii. Drug or alcohol abuse for a Member twelve (12) years of age or older;

iii. Pregnancy;

iv. Family Planning, including termination of pregnancy; and

i. Sexually transmitted diseases (STDs) or HIV/AIDS for a Member twelve (12) years of age or older.

b. Initial mental health assessments; and

c. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

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B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1. A PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergency and urgent questions from the Member in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member, and direct the Member to the most appropriate level of service based on the Member's condition.

2. All services shall be provided in the manner and time frames set forth in CalOptima Policy GG.1113: Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

   a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima identification card, or shall perform an eligibility verification using CalOptima's Provider Portal at www.caloptima.org.

   b. Prior Authorization does not guarantee eligibility at the time services are rendered.

   c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Direct Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers:

   a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

   b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

   c. Request for Retrospective Review subject to the limitations described in Section II.J. of this Policy.

2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:

   a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

   b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

   c. Request for Retrospective Review subject to the limitations described in Section II.J. of this policy.

3. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be addressed within seventy-two (72) hours or as soon as the Member's health condition requires.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima or a Health Network, as applicable, prior to a Member's admission to inpatient status.

5. All CalOptima and Health Network authorization requests must include the clinical records that validate the need for the requested item or service.

D. Hospital Notification of Emergency Services

1. A hospital shall notify CalOptima or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification system is implemented, hospital shall use its best efforts to provide such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services.

2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima or the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence.

E. Prior Authorization Request from Non-Contracted Provider

1. Medically Necessary Post-Stabilization Services

a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve or resolve the Member's stabilized medical condition.

b. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a completed and signed authorization request form from the facility to CalOptima or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare and OneCare Connect:

i. Identifying information including: Member name, birthdate, CIN and gender;

ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation to include at a minimum:

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a) History and physical;

b) Vital signs; and

c) Laboratory and/or radiology results.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

c. For a CalOptima Direct Member enrolled in the Medi-Cal or OneCare Connect program, CalOptima shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary post-stabilization services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

d. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of a written request that fully complies with Section III.E.1.b. of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the non-contracted Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii. In the case where the Health Network denies such request and informs the non-contracted Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

e. For a Health Network Member enrolled in the OneCare or OneCare Connect program, a Health Network shall approve or deny a non-contracted Provider's Prior Authorization request for post-stabilization services within sixty (60) minutes after receipt of a written request that fully complies with Section III.E.1.b. of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a CalOptima Direct Member enrolled in the Medi-Cal program, CalOptima shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-

contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.

2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's Customer Service Department (714-246-8500 or toll-free at 888-587-8088/TDD/TTY: 1-800-735-2929), or the Member's Health Network.

3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734/TDD/TTY: 1-800-735-2929), or the Member's Health Network.

4. For OneCare Connect, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima's OneCare Connect Customer Service Department (toll-free 1-855-705-8823 or TDD/TTY: 1-800-735-2929), or Member's Health Network.

5. CalOptima or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

6. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.

7. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima or the Health Network is unable to provide services within the network, in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

2. CalOptima or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima or the Health Network is unable to provide the services within the network. CalOptima or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima along with medical justification sufficient

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to make a determination and the physician signature. CalOptima shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.

4. CalOptima or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

5. CalOptima or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Policy EE.1141: CalOptima Provider Contracts.

6. CalOptima or a Health Network shall provide continued access as follows:

   a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship, if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

   b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, GG.1401: Pharmacy Authorization Process, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

   c. For newly enrolled OneCare Connect beneficiaries, for up to twelve (12) months for Medi-Cal and Medicare Covered Services, to an out-of-network Provider with whom the Member has had an ongoing relationship, if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal or Medicare rates, in accordance with CalOptima Policy CMC.6021a: Continuity of Care for New Members.

H. Denials, Deferrals, and Modifications of Prior Authorization Requests

1. Preferred Network Specialist Physician. CalOptima or a Health Network may redirect specialty care Prior Authorization requests to a preferred network Specialist Physician under the following conditions:

   a. All modification, denial, and notification requirements are followed pursuant to regulation requirements; and

   b. The preferred Specialist Physician is selected based on the following:

      i. A demonstrated ability to provide the services requested;

      ii. Prolific experience providing the services requested;

      iii. Volume of the requested care previously provided;

      iv. An existing relationship with CalOptima or the Health Network, as applicable;

      v. A proven ability to maintain adequate Member access;

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vi. A proven ability to provide care coordination;

vii. No existing issues related to continuity of care or Tertiary service needs; and

viii. For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist.

a. CalOptima may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

i. A CalOptima Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;

ii. The Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and

iii. Upon receipt of the recommendation of the external review agency, the CalOptima Medical Director shall conduct the final review and determination.

b. The Quality Improvement (QI) Department shall maintain a list of Board-Certified specialists, and the list will be reviewed annually by the Quality Improvement Committee (QIC).

3. Tertiary Care.

a. CalOptima or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.

b. CalOptima shall only authorize Tertiary Care services under the following circumstances:

i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;

ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;

iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima; and

v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed health professional;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.

c. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

i. Only a qualified, licensed physician shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity.

ii. Only a qualified, licensed clinical psychologist or Board-Certified psychiatrist shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and

iii. Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

5. Notification of UM Decision

a. CalOptima and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare and OneCare Connect, CalOptima and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Policy MA.6042: Organization Determinations.

b. If Medical Necessity criteria are not met, and review by a CalOptima or Health Network physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

c. For routine (non-urgent) authorization requests, if CalOptima or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

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I. Availability of CalOptima UM Staff and Services

1. CalOptima's UM Department shall provide Members or potential Members access to information, about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, OneCare Evidence of Coverage, and OneCare Connect Member Handbook available in-print and on the CalOptima website at www.caloptima.org.

2. CalOptima's UM Department shall provide Practitioners access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima website at www.caloptima.org.

3. UM staff shall be available for inbound calls regarding UM issues during CalOptima normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima's Customer Service Department and routed to appropriate UM staff.

   a. UM staff shall provide a toll-free number (888-587-8088) and accept collect calls regarding UM issues and will also accept calls at 714-246-8500.

   b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

   c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

   d. UM staff shall be accessible to callers who have questions about the UM process.

   e. UM physicians shall be available to answer denial determination questions during normal business hours and after hours at 888-587-8088 and accept collect calls regarding UM issues and will also accept calls at 714-246-8500. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

   f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Policies DD.2002: Cultural and Linguistic and Services, MA.4002: Cultural and Linguistic and Services, and CMC.4002: Cultural and Linguistic and Services (CalOptima is able to receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima shall provide language assistance services free of charge to Members. CalOptima shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Policies DD.2002: Cultural and

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Linguistic Services, MA.4002: Cultural and Linguistic and Services, and CMC.4002: Cultural and Linguistic and Services.

7. CalOptima shall send a CalOptima Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Policy DD.2005: Member Handbook Requirements. The handbook will note availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima shall inform Medi-Cal Members of the availability of the CalOptima Member Handbook/Evidence of Coverage.

9. Annually, CalOptima shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members, and the Member Handbook, for OneCare Connect Members.

J. Failure of a Health Network or CalOptima department to comply with CalOptima's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima's authorization process and reports to the Utilization Management Committee (UMC), Audit & Oversight Committee (AOC), and/or the Compliance Committee.

1. Continued non-compliance may lead to issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Timeframes for Medi-Cal Services Decisions and Notifications
B. Timeframes for OneCare and OneCare Connect Service Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.4002: Cultural and Linguistic and Services
G. CalOptima Policy CMC.6021a: Continuity of Care for New Members
H. CalOptima Policy DD.2003: Member Identification and Eligibility Verification
I. CalOptima Policy DD.2002: Cultural and Linguistic Services
J. CalOptima Policy DD.2005: Member Handbook Requirements
K. CalOptima Policy EE.1141: CalOptima Provider Contracts
L. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
M. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
N. CalOptima Policy GG.1113: Specialty Practitioner Responsibilities
O. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
P. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model

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Q. CalOptima Policy GG.1401: Pharmacy Authorization Process
R. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
S. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
T. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
U. CalOptima Policy HH.2002Δ: Sanctions
V. CalOptima Policy HH.2005Δ: Corrective Action Plan
W. CalOptima Policy MA.4002: Cultural and Linguistic and Services
X. CalOptima Utilization Management Program
Y. Department of Health Care Services All Plan Letter (APL) 18-023 California Children's Services Whole Child Model Program
Z. Department of Health Care Services All Plan Letter (APL) 17-018: Outpatient Mental Health Services
AA. Department of Health Care Services All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
BB. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 16-002 (supersedes DPL 15-003): Continuity of Care-Revised 07/05/16
CC. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
DD. Health and Safety Code, Sections 1363.5 and 1367.01
EE. Medi-Cal Member Handbook
FF. OneCare Evidence of Coverage
GG. OneCare Connect Member Handbook
HH. Title 28, California Code of Regulations (CCR), §1300.71.4
II. Title 42, Code of Federal Regulations (CFR), §§ 422.113(c), 438.114 (a), 438.404(c)(5), and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/02/2009	Department of Health Care Services (DHCS)
02/24/2013	Department of Health Care Services (DHCS)
07/11/2014	Department of Health Care Services (DHCS)
08/17/2015	Department of Health Care Services (DHCS)
06/26/2018	Department of Health Care Services (DHCS)
04/19/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Authorization and Processing of Referrals	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Inpatient and outpatient Covered Services furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services that are Medically Necessary, and to what amount, duration, and scope, except in the case of an emergency.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.

Term	Definition
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service*: Prospective or concurrent service requests where no extension is requested or needed *Non pharmacy requests	Approve, Modify or Deny within 5 working days[1] of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances ~~but~~ no ~~longer~~ later than 14 calendar days following receipt of request. "all information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Electronic or written communication within 24 hours of making the decision. ~~dated and postmarked within 5 working days of receipt of "all information".~~ **Member:** Written notice must be dated and postmarked within 2 working days of making the decision~~.~~.
Routine (Non-Urgent) Pre-Service (Deferral), Extension needed:* • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request. *	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. If no decision is made within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.	**Extension - Practitioner/Member:** Written NOA "delay" notification within14 days of receipt of the request for services. • The delay NOA shall specify the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also include the anticipated date when a decision will be rendered.

[1] Working days = Monday through Friday excluding California State Holidays https ://www.ftb.ca.gov/aboutftb/holidays.shtml

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Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Expedited Requests (Pre-Service)*: No extension requested or needed Requests where a provider indicates or the Plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. All necessary information received at time of initial request	Approve, modify or deny the request within 72 hours from receipt~~receipt~~ of request	**Practitioner:** Electronic or written~~-~~ notification within 72 hours of the request. ~~**Member:**~~ ~~Oral notification within 72 hours from receipt of request~~ **Member:** Written notice within 72 ~~working~~ hours of the~~w~~ receipt of the request for services~~days of making the decision~~.
Expedited Authorization (Pre-Service)*,Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the Plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request.	May extend up to 14 calendar days upon expiration of the 72hour timeframe. **Additional Requested Information is Received:** A decision must be made within 72 hours of receipt of requested information. If no decision is made within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.	**Practitioner/Member:** Written NOA "delay" notification within 72 hours of receipt of the request for services. • The delay NOA shall specify the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also include the anticipated date when a decision will be rendered.

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Concurrent*: Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the ~~request~~decision, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3). **Practitioner / Member:** Written notice within 3 calendar days after the oral notification. For terminations, suspensions, or reductions of previously authorized services, Plans must notify beneficiaries at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review*: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of request.
Post-Service*: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more ~~that~~than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of the information necessary to make the determination.

Type of Request	Decision	Notification Timeframes
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	
Hospice - Inpatient Care*:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** Written notice within 2 working days or making the decision.

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service*: Prospective or concurrent service requests where no extension is requested or needed *Non pharmacy requests	Approve, Modify or Deny within 5 working days[1] of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "all information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Electronic or written communication within 24 hours of making the decision. **Member:** Written notice must be dated and postmarked within 2 working days of making the decision.
Routine (Non-Urgent) Pre-Service (Deferral), Extension needed:* • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request. *	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. If no decision is made within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.	**Extension - Practitioner/Member:** Written NOA "delay" notification within 14 days of receipt of the request for services. • The delay NOA shall specify the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also include the anticipated date when a decision will be rendered.

[1] Working days = Monday through Friday excluding California State Holidays https ://www.ftb.ca.gov/aboutftb/holidays.shtml

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Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Expedited Requests (Pre-Service)*: No extension requested or needed Requests where a provider indicates or the Plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. All necessary information received at time of initial request	Approve, modify or deny the request within 72 hours from receipt of request	**Practitioner:** Electronic or written notification within 72 hours of the request. **Member:** Written notice within 72 hours of the receipt of the request for services.
Expedited Authorization (Pre-Service)*, Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the Plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request.	May extend up to 14 calendar days upon expiration of the 72hour timeframe. **Additional Requested Information is Received:** A decision must be made within 72 hours of receipt of requested information. If no decision is made within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.	**Practitioner/Member:** Written NOA "delay" notification within 72 hours of receipt of the request for services. • The delay NOA shall specify the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also include the anticipated date when a decision will be rendered.

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Concurrent*: Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the decision, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3). **Practitioner / Member:** Written notice within 3 calendar days after the oral notification. For terminations, suspensions, or reductions of previously authorized services, Plans must notify beneficiaries at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review*: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of request.
Post-Service*: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of the information necessary to make the determination.

Type of Request	Decision	Notification Timeframes
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	
Hospice - Inpatient Care*:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** Written notice within 2 working days or making the decision.

Attachment B

TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or needed	Within 5 working days of receipt of "all information" reasonably necessary to render a decision, and in all circumstances no longer than 14 calendar days. "all information" means: Complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for service.
Routine (Non-Urgent) Pre-Service (Deferral) Extension needed • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests and justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request. An extension ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** A written member notice of denial issued within 28 calendar days from the receipt of the original referral request.	**Extension - Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** • Written notice within 14 calendar days of receipt of request. The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension - Practitioner / Member:** Written notice within 2 working days of making the decision, not to exceed 28 calendar days from receipt of the request.

Attachment B
TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Type of Request	Decision	Notification Timeframes
Expedited Authorization (Pre-Service): No extension requested or needed Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. All necessary information received at time of initial request.	Within 72 hours from receipt of request	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. Member – Medi-Cal: Written notification within 72 hours from receipt of request. **Member - OCC:** Oral notification within 72 hours from receipt of request. **Practitioner/Member:** Written notice within 2 working days of making the decision.
Expedited Authorization (Pre-Service): Extension needed Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	May extend up to 14 calendar days upon expiration of the 72-hour timeframe. Notify practitioner and member using the "delay" template and insert specifics about that has not been received, what consultation is needed and/or the additional examination or testes required to make a decision and the anticipated date on which a decision will be rendered. **Additional Requested Information is Received:** A decision must be made within 1 working day of receipt of requested information. **Additional Information Incomplete or not Received** Any decision delayed beyond the timeframe limits is considered a denial and must be processed immediately as such.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision, and no later than the expiration date of the extension. **Member - OCC Only:** Oral notification within 2 working days from making the decision, and no later than the expiration date of the extension. **Practitioner/Member:** Written notice within 2 working days of making the decision.

Type of Request	Decision	Notification Timeframes
Concurrent: Concurrent review of treatment regimen already in place, (inpatient, ongoing /ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the request. **Practitioner/Member:** Written notice within 3 calendar days after the oral notification.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Within 30 calendar days from receipt of request.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of request.
Post-Service: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of the information necessary to make the determination.

Type of Request	Decision	Notification Timeframes
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** Written notice within 2 working days or making the decision.

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: February 27, 2020

ALL PLAN LETTER 20-003
SUPERSEDES ALL PLAN LETTER 19-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NETWORK CERTIFICATION REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the Annual Network Certification (ANC) requirements pursuant to Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197.[2, 3]

BACKGROUND:
The ANC provides a prospective look at the MCP's network for the upcoming contract year (CY).[4] MCPs are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their networks. DHCS reviews all MCP network submissions and provides an assurance of the MCPs' compliance with ANC standards to the Centers for Medicare and Medicaid Services (CMS) before the CY begins.[5]

POLICY:
Federal and state law and regulation require DHCS to certify each MCP's aggregate network every year.[6, 7] MCPs are required to annually submit ANC documentation to

[1] This APL applies to all MCPs and Senior Care Action Network (SCAN).
[2] 42 CFR Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.
[3] WIC section 14197 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.
[4] For purposes of this APL, the CY is the MCP's fiscal year except for the following MCPs: Family Mosaic, AIDS Healthcare Foundation, and SCAN Health Plan. The CY for those MCPs is the calendar year.
[5] 42 CFR section 438.207(d).
[6] A network is defined as Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and any other providers that subcontract with an MCP for the delivery of Medi-Cal covered services.
[7] 42 CFR section 438.207(c)(2); WIC section 14197.

DHCS to demonstrate their capacity to serve the anticipated membership in their service areas.[8, 9]

Specifically, DHCS must ensure that MCPs:

- Contract with the required number and mix of primary and specialty care providers;
- Provide medically necessary services needed for their anticipated membership and utilization;
- Confirm the geographic location of network providers complies with time and distance standards; and
- Comply with service availability, physical accessibility, out-of-network (OON) access, timely access, continuity of care, and 24/7 language assistance requirements.[10,]

I. MEDI-CAL MANAGED CARE HEALTH PLANS ANNUAL NETWORK CERTIFICATION

A. Annual Network Certification Components

1. Network Providers[11]

Each MCP must maintain and monitor an appropriate network that includes the following network provider types to ensure the MCP's network has the capacity to provide all medically necessary services:

- Adult and pediatric PCPs, including non-physician medical practitioners;[12]
- Obstetrician-gynecologists (OB/GYN);
- Adult and pediatric core specialists;[13]

[8] 42 CFR sections 438.68, 438.206, and 438.207.
[9] For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment B of this APL.
[10] 42 CFR section 438.207(a) - (b); WIC section 14197.
[11] For more information on networks and network providers, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, or any subsequent revision to this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[12] Non-physician medical practitioners include nurse practitioners, physician assistants, and certified nurse midwives (CNMs).
[13] Core specialists are listed in Attachment A of this APL.

- Adult and pediatric mental health outpatient providers;[14]
- Hospitals;
- Pharmacies; and
- Ancillary services.[15]

Additionally, MCPs operating in County Organized Health Systems (COHS) or Cal MediConnect counties must contract with and monitor an appropriate network of Managed Long Term Services and Supports (MLTSS) providers.[16]

2. Network Capacity and Ratios

Network Capacity

In order to support current and anticipated membership, MCPs must meet or exceed network capacity requirements as defined in the MCP contract.[17] Imperial, Regional, San Benito, Two-Plan, and Geographic Managed Care plan model MCPs must maintain a network capacity to serve 60% of all eligible members in their service areas or the current member enrollment in the MCP, whichever is higher. COHS plan model MCPs are required to have a network with the capacity to serve 100% of eligible members in the county. MCPs must adjust the number of network providers proportionally to accommodate any changes in enrollment.

Provider to Member Ratios

MCP networks must meet the full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician to every 1,200 members.[18] DHCS calculates the network providers' FTE for adult and pediatric PCPs and total physicians as described in Attachment B, Exhibit A-2.[19] MCPs may use non-physician medical practitioners to improve primary care access; however, they must not include them for purposes of calculating the PCP and Total Physician Ratios.

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[14] State Plan Amendment (SPA) 14-012. SPAs are available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx.
[15] MCP Contract, Exhibit A, Attachment 6, Network Composition. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[16] MLTSS providers include Community Based Adult Service providers, Long Term Care providers, Multipurpose Senior Services Program, Intermediate Care Facilities and Skilled Nursing Facilities.
[17] MCP Contract, Exhibit A, Attachment 6, Network Capacity.
[18] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[19] Attachment B of this APL serves as the ANC Instruction Manual. The ANC Instruction Manual provides MCPs with policy details, ANC checklists, and ANC scenarios.

MCPs are required to meet provider to member ratios for adult and pediatric outpatient mental health providers to ensure access to MCP-covered outpatient non-specialty mental health services. DHCS annually calculates the number of providers necessary to cover each service area by taking into account service utilization, dedicated provider time for providing mental health services, and expected usage by adult and pediatric populations.[20] DHCS will provide each MCP with the required number of providers to cover their service areas.

Additionally, in order to ensure consistency amongst delivery systems and compliance with mental health parity requirements, MCPs that contract with DHCS to provide Specialty Mental Health Services (SMHS) must meet the provider to member ratios by which the county mental health plans are held for outpatient SMHS and psychiatry services.

3. Mandatory Providers

In accordance with WIC section 14087.325, MCPs must offer to contract with each of the following mandatory provider types in their service area, where available: Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).[21] Furthermore, CMS State Health Official letter (SHO) #16-006 mandates that MCPs contract with at least one FQHC, one RHC, and one Freestanding Birthing Center (FBC) in their service areas, where available.[22]

Further, MCPs must contract with a minimum of one CNM and one licensed midwife (LM) in their service areas, where available, in accordance with state

[20] MCP Contract, Exhibit A, Attachment 20, Outpatient Mental Health Services Providers.
[21] WIC section 14087.325 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14087.325. https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14087-325.html.
[22] SHO Letter #16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.

and federal network adequacy requirements.[23, 24, 25] MCPs that have a FBC in their network are not exempted from the requirement to contract directly with a minimum of one CNM and one LM. MCPs must ensure CNMs and LMs are properly enrolled and credentialed when establishing a direct contract with these providers. For additional information on FBC, CNM, and LM requirements, see APL 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services, including subsequent revisions to this APL.

Federal and state laws and regulations provide protections for American Indians and American Indian Health Services.[26] Indian Health Facilities (IHFs) are not required to contract with MCPs but can voluntarily enter into a contract with an MCP at any time. However, MCPs are required to offer to contract with each IHF in their service area(s).[27] MCPs that do not have an IHF in their network must allow eligible members to obtain services from an OON IHF.[28]

MCPs must annually demonstrate efforts to improve access to services customarily provided by mandatory providers. MCPs that do not have a contract with a mandatory provider must submit documentation to DHCS for review and approval detailing the reasons the MCP was unable to contract, as outlined in Attachment B, Exhibit A-3.

4. Time and Distance Standards

DHCS established network adequacy standards in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services.[29, 30] These standards require MCPs to meet both time and

[23] MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.
[24] WIC section 14132.39 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.39. WIC section 14132.4 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.4.
[25] 42 of the United States Code (USC) section 1396d(a)(17). The USC is available at: http://uscode.house.gov/.
[26] 42 CFR section 438.14; 22 CCR section 55120.
[27] Title 22 of the California Code of Regulations (CCR) section 55120. 22 CCR section 55120 is available at: https://govt.westlaw.com/calregs/Search/Index.
[28] 42 CFR section 438.14.
[29] 42 CFR section 438.207.
[30] For more information on network adequacy standards, see Attachment A of this APL.

distance standards based on county population density.[31, 32] Time and distance standards apply to the following provider types:[33]

- Adult and pediatric PCPs;
- Adult and pediatric core specialists;
- OB/GYN primary care services;
- OB/GYN specialty care services;
- Hospitals;
- Adult and pediatric mental health providers; and
- Pharmacies.

If a member elects to use an OB/GYN as their PCP and the OB/GYN agrees to act as the member's PCP, the MCP must ensure timely access is met even if time and distance standards are not met for that member.[34]

MCPs must create and submit accessibility analyses and narratives, if applicable, to demonstrate compliance with time and distance standards. The accessibility analyses must demonstrate coverage of the MCP's entire service area, for all ZIP codes, to account for all current and anticipated membership. Attachment B, Exhibit B details the submission requirements pertaining to the accessibility analyses and narratives.

DHCS may authorize MCPs to use telehealth and mail order pharmacy(ies), where necessary, for purposes of complying with time and distance standards (see Section B-3: "Telehealth" and Section B-4: "Mail Order Pharmacy" of this APL).[35]

5. Timely Access

Timely Access Survey
DHCS conducts a timely access survey that measures compliance with appointment time standards.[36] DHCS includes the annual results of the retrospective timely access survey as a component of the ANC. The survey includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for

[31] WIC section 14197(b).
[32] For more information on county populations, see Attachment A of this APL.
[33] 42 CFR section 438.68(b).
[34] Health & Safety Code section 1367.69.
[35] WIC section 14197(e)(4).
[36] For more information on network adequacy standards, see Attachment A of this APL.

pediatric and adult members; the availability of interpreter services; and the languages spoken by the network providers or provider site locations.

Additionally, as part of the timely access survey, DHCS contacts each MCP call center to confirm call center compliance with wait time standards and call center awareness of a member's right to receive interpretation services.[37, 38]

DHCS provides the results of its timely access survey to MCPs on a quarterly basis and annually determines the rate of compliance. MCPs must submit a response to any timely access deficiencies found in the quarterly survey results and identify any changes or corrections necessary to achieve compliance with timely access requirements.

Audits & Investigations Timely Access Verification Study
DHCS' Audits and Investigations Division (A&I) routinely performs medical review audits of MCPs. A&I reviews the MCPs' infrastructure to assess compliance with all access to care requirements, including but not limited to, the following:

- Service availability;
- Physical accessibility;
- OON access;
- Timely access;
- Continuity of care; and
- 24/7 language assistance.

If there are non-compliant findings in Category 3 – Access and Availability of the A&I medical audit, those findings are noted in the MCP's ANC Corrective Action Plan (CAP).

B. Medi-Cal Managed Care Health Plan Alternative Access Standards

1. Alternative Access Standard Request

MCPs must submit an Alternative Access Standard (AAS) request to DHCS for review and approval if the MCP is unable to meet time and distance standards and has exhausted all reasonable contracting options with nearer

[37] 28 CCR section 1300.67.2.2(c)(10).
[38] 22 CCR section 53853(c).

providers.[39, 40] MCPs must submit all AAS requests, even if they were previously approved, on an annual basis or any time a network change results in the MCP not meeting time and distance standards.

In order for the request to be considered for the ANC, MCPs must submit the AAS request to DHCS with the ANC exhibits no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). DHCS will make best efforts to approve any AAS requests received after the deadline but cannot guarantee a decision prior to the CMS submission deadline.

Attachment B, Exhibit C, details the submission requirements for AAS requests. MCPs must explain the facts and circumstances for each AAS request and detail at a minimum, the following:

- Name and address of nearest network provider;
- Driving time/distance to the nearest network provider;
- Name and address of at least two of the nearest OON provider(s) utilizing provider resource lists;
- Driving time/distance to at least two of the nearest OON provider(s utilizing provider resource lists;
- Number of members residing in the impacted ZIP code;
- Reasons for inability to contract with nearer providers; and
- Description of contracting efforts.

At a minimum, MCPs must utilize the following provider resource lists and identify the providers on the AAS request:

- Health Care Options.
- Fee for Service Open Data Portal.
- Office of Statewide Health Planning and Development.

DHCS approves or denies AAS requests on a ZIP code and provider type basis, including specialty type.[41] DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the MCP. The AAS request is evaluated in relation to other MCP's AAS requests for the same service area, and considers the Health Professional

[39] WIC sections 14197(e)(1)–(2).
[40] The AAS request template is available in Attachment C.
[41] WIC section 14197(e)(3).

Shortage Area (HPSA) designation of the requested service area, where applicable.[42]

MCPs must maintain documentation of their efforts to contract with nearer providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearer OON providers during the review process. Following DHCS' review, DHCS will send an AAS determination letter informing MCPs of AAS approvals and denials in each service area.[43] An AAS approval is valid for one CY and must be approved every year thereafter if the MCP still needs an AAS.

2. Additional Medi-Cal Managed Care Health Plan Requirements for Approved Alternative Access Standards

MCPs that receive AAS approvals from DHCS must inform their affected members of all approved AAS through the MCP's Member Handbook and post all approved AAS, specified by county, on the MCP's internet website.[44] Each MCP must post the approved AAS on its website no later than 30 days after DHCS publishes the statewide AAS approvals on the DHCS website.[45]

MCPs that have an approved AAS for a core specialist are required to assist any requesting member in obtaining an appointment with an appropriate OON core specialist. When assisting the member, the MCP must make its best effort to establish a member-specific case agreement with an OON core specialist at the Medi-Cal fee-for-service rate or a mutually agreed upon rate. Either that, or the MCP must arrange for an appointment with an in-network specialist, unless the MCP has already attempted to establish a member-specific case agreement with the core specialist in the most recent fiscal year and the core specialist has refused to enter into an agreement.[46] The OON core specialist must be within the MCP's applicable time and distance and timely access standards and, in cases where the OON specialist is not within time and distance standards, the MCP must arrange for non-emergency medical transportation or non-medical transportation.[47]

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[42] More information on HPSA designations is available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.
[43] WIC section 14197(e)(3).
[44] WIC section 14197.04(c).
[45] The AAS approvals are posted after the ANC submission to CMS and after CAPs are closed.
[46] WIC section 14197.04(a).
[47] WIC section 14197.04(b).

3. Telehealth

MCPs may use telehealth to meet time and distance standards if they are unable to contract with an in-person provider.[48, 49] MCPs cannot require members to access services via telehealth in place of in-person services.[50] MCPs that request to utilize a telehealth provider as an alternative access to care must submit supporting documentation and evidence of contracting efforts to DHCS for review and approval as described in Attachment B, Exhibit C-1.

If a MCP elects to utilize telehealth for compliance with time and distance standards, the telehealth services must be available to all members in the defined service area. This applies regardless of whether the member is assigned to a network provider or subcontractor, or which network provider or subcontractor the member is assigned to. MCPs may have telehealth providers that are only available to members assigned to a subcontractor as long as other members have access to telehealth services through other means. Telehealth providers and telehealth services must also meet the telehealth criteria outlined in the Medi-Cal Provider Manual and APL 19-009 (Revised): Telehealth Services Policy, including subsequent revisions to this APL.[51] In addition, telehealth providers must be certified and enrolled in the Medi-Cal program and credentialed by the MCP.[52]

Since MCPs cannot require a member to access services via telehealth, MCPs must provide transportation to a network provider within time and distance and timely access standards for medically necessary services, when requested by a member.[53]

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[48] WIC section 14197(e)(1)(A).
[49] WIC section 14197(e)(4).
[50] WIC section 14132.72(f) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.72.
[51] The Medicine: Telehealth section of the Medi-Cal Provider Manual is available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.
[52] For more information on provider certification and enrollment, see APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment, including subsequent revisions to this APL.
[53] For more information on transportation service, see APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services, including subsequent revisions to this APL.

4. Mail Order Pharmacy

MCPs may utilize mail order pharmacies to meet time and distance standards if they make reasonable attempts to contract with a pharmacy with a physical location before utilizing a mail order pharmacy.[54] MCPs that request to use a mail order pharmacy as an alternative access to care must submit supporting documentation and evidence of all contracting efforts to DHCS for review and approval as outlined in Attachment B, Exhibit C-2.

When using mail order pharmacies, MCPs must have procedures in place to ensure that all medications are delivered in a timely manner, consistent with the member's medical need, even if medications cannot be sent through the mail, the member cannot receive medications through the mail, or the member has confidentiality concerns about receiving medications by mail.[55]

5. Delivery Structure Alternative Access Standard

In cases where an MCP is unable to meet time standards or distance standards due to its delivery structure, DHCS is authorized to determine if the MCP is capable of delivering the appropriate level of care and access to members through an AAS.[56] In order to be considered for an AAS, the MCP must provide a written request to DHCS following the instructions in Attachment B, Exhibit C-3.[57]

DHCS will provide the requesting MCP a template to submit its formal AAS justification.[58] DHCS will review all information submitted by the MCP to determine if the MCP's formal justification for AAS meets the needs of its members and ensures appropriate and timely access to care.[59] An approved AAS is valid for one CY. MCPs must submit an updated AAS justification if the MCP still requires the specified AAS at the end of the CY.

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[54] WIC section 14197(e)(1)(A).
[55] WIC section 14185(a) is available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6.
[56] WIC section 14197(e)(1)(B).
[57] WIC section 14197(e)(2).
[58] MCPs must request the AAS justification template by following the instructions in Attachment B.
[59] WIC section 14197(e)(3).

C. Annual Network Certification Submission Requirements

1. Annual Network Certification Exhibit Submission

Each MCP must submit complete and accurate ANC data and information to DHCS that reflects the MCP's network for each service area no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). MCPs must submit all required ANC exhibits, as outlined in Attachment B and, if applicable, Attachment C, with the correct file labeling conventions through the DHCS Secure File Transfer Protocol site. MCPs that do not submit ANC exhibits by the deadline may be subject to corrective action and/or monetary sanctions. Additionally, if DHCS receives multiple revised submissions from an MCP, DHCS may not accept the submission and the MCP may be subject to corrective action and/or monetary sanctions due to non-compliance with the submission requirements specified in this APL and its attachments.

2. 274 File Submission

MCPs must upload network providers in the 274 file submission in accordance with this APL and APL 16-019: Managed Care Provider Data Reporting Requirements, including subsequent revisions to these APLs. DHCS utilizes only the most current month's 274 file submission at the time of the ANC submission to determine compliance with the MCP's contractual provider to member ratios and mandatory providers. If DHCS is unable to access the required monthly 274 file submission due to an MCP's untimely submission, a corrective action and/or monetary sanctions may be applied for data submission timeliness.

3. Certification of Documents and Data

MCPs are required to submit complete, accurate, reasonable, and timely ANC exhibits and 274 file submissions in compliance with state and federal law and this APL. MCPs must submit their certification statement on MCP letterhead by the final business day of each month to their contract manager. Repeated failure to submit this certification statement may result in the imposition of a CAP and monetary sanctions.[60]

[60] For more information, see APL 17-005: Certification of Document and Data Submissions, including subsequent revisions to this APL.

D. Annual Network Certification Validations

1. Provider Validation

DHCS validates a statistically valid sample of each MCP's network of adult and pediatric PCPs, OB/GYNs, adult and pediatric core specialists, adult and pediatric mental health outpatient providers, hospitals, and pharmacies to ensure network providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS may request signed contract pages confirming there is a current executed contract with the provider or facility.

2. Mandatory Provider Validation

DHCS validates a statistically valid sample of each MCP's network of FQHCs, RHCs, IHFs, FBCs, CNMs and LMs to ensure the mandatory providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS will review the evidence of contracting efforts and any additional documentation necessary to ensure compliance. DHCS may rescind the approval if the MCP cannot provide sufficient evidence and documentation of contracting efforts.

3. Alternative Access Standard Validation

If an MCP submits an AAS request using the templates in Attachment C, the MCP must describe all contracting efforts to support the AAS request. Through the AAS validation process, DHCS will request evidence of contracting efforts, including evidence of why the MCP was unable to contract, which must include supporting documentation as described in Attachment B, Exhibit C-4.

DHCS' AAS validation process includes a comparison of the MCP's narrative submitted through Attachment C with that of other MCPs serving the same service area and a review of the evidence on contracting efforts that support each AAS request.[61] DHCS may rescind an approved AAS if the MCP cannot provide sufficient evidence of contracting efforts.

[61] WIC Section 14197(e)(3).

II. NETWORK REQUIREMENTS FOR MEDI-CAL MANAGED CARE HEALTH PLAN SUBCONTRACTORS

MCPs are permitted to contract with network providers and subcontractors to fulfill their obligations to arrange for and deliver health care services under the MCP contracts. If an MCP delegates the responsibility to deliver Medi-Cal covered services from the MCP to a subcontractor, including but not limited to, a health plan partner, medical group, Independent Physician Association (IPA), or clinic, the subcontractor must have an adequate network that meets the requirements set forth in this APL. MCPs must allow members to access OON providers if the subcontractor does not have an adequate network. This requirement applies to any deficient network component(s), as required by state and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.[62, 63]

MCPs and their subcontractors must authorize services through OON providers if the network of a subcontractor fails to meet network adequacy requirements. In doing so, members may utilize any provider in or out of the MCP's network regardless of IPA or medical group affiliation. DHCS prohibits the use of an administrative subcontractor, including but not limited to, an administrative services organization, to restrict an assigned member to a network provider's network if that network fails to meet network adequacy standards. Although DHCS certifies the aggregated MCP network, these network requirements apply.

MCPs must have contractual provisions and policies and procedures for ensuring each subcontractor has an adequate network including the use of administrative subcontractors that facilitate the referral and/or utilization management process. MCPs' contractual provisions and policies and procedures must align with DHCS' ANC process to assess the network adequacy of all subcontractors that are contracted to provide Medi-Cal covered services.

MCPs must also have contractual provisions and policies and procedures for imposing CAPs and monetary sanctions on subcontractors when they are out of compliance with network adequacy requirements. This includes timely access requirements under state and federal law, any subcontractual requirements, and or DHCS contract requirements. MCPs must report all significant instances of non-compliance to DHCS, including CAPs or monetary sanctions imposed on subcontractors.

[62] MCP Contract, Exhibit A, Attachment 9, Out-of-Network Providers.
[63] 42 CFR section 438.207.

MCPs must also report network provider or subcontractor non-compliance issues when those issues result in the MCP's non-compliance with contractual and legal requirements.[64] MCPs must report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their Managed Care Operations Division (MCOD) contract manager within three business days of discovery or imposition.[65]

III. NON-COMPLIANCE WITH NETWORK CERTIFICATION REQUIREMENTS

A. Medi-Cal Managed Care Health Plan Preliminary Findings of Non-Compliance

If an MCP's ANC submission is timely, DHCS will provide technical assistance by supplying a worksheet containing preliminary ANC findings. MCPs have two weeks to correct any findings that were caused by a reporting error and must begin to remedy findings that would result in a CAP before DHCS imposes a formal ANC CAP. MCPs may request an extension for meeting the ANC submission deadline by providing a justification, including the reason(s) why the MCP requires additional time. In the event the MCP's ANC submission is untimely, DHCS will be unable to provide technical assistance and will impose a CAP.

B. Medi-Cal Managed Care Health Plan Corrective Action Plans and Monetary Sanctions

DHCS will place MCPs who fail to meet the ANC components or rectify findings identified in the preliminary ANC findings worksheet under an ANC CAP. As part of the CAP process, MCPs must submit a plan of action detailing the steps the MCP will take to remedy the ANC deficiency findings. MCPs have six months to correct all deficiencies and must comply with all CAP mandates set forth below until DHCS closes the CAP.

Additionally, DHCS has authority to impose monetary sanctions for failure to comply with network adequacy requirements[66] DHCS will impose sanctions for not meeting the ANC components at the end of the CAP period. Finally, DHCS

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[64] For more information on network provider or subcontractor non-compliance, see APL 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations, and Decertifications, including subsequent revisions to this APL.
[65] For more information on subcontractual non-compliance, see APL 17-004: Subcontractual Relationships and Delegation, including subsequent revisions to this APL.
[66] WIC section 14197.7.

reserves the right to impose additional sanctions on an MCP for continued failures to comply with all network adequacy requirements, CAP mandates, or the inability to correct a deficiency within the CAP timeframe.

C. Medi-Cal Managed Care Health Plan Corrective Action Plan Mandates

An MCP under an ANC CAP must comply with the following mandates:

- Authorize OON access to medically necessary providers within timely access standards and applicable time and distance standards, regardless of associated transportation or provider costs until the CAP is closed by DHCS;
- Provide status updates that demonstrate action steps the MCP is undertaking to correct the CAP deficiency(ies) bimonthly (once every two months); and
- Demonstrate its ability to effectively provide OON access information to members and ensure that its MCP member services staff, network providers, and subcontractors are trained on the mandates.

DHCS will review the bimonthly submissions and the MCP's deliverables to ensure compliance with CAP mandates and provide technical assistance if additional corrective action is required.

If an MCP submits an updated or new AAS to rectify a network deficiency, the MCP must continue to provide transportation services for members to any network providers for which it has an approved AAS and approve requested OON access until DHCS has reviewed and approved the updated or new request.

MCPs are also required to ensure network providers and subcontractors adhere to the CAP mandates and comply with OON access requirements.

IV. POST NETWORK CERTIFICATION MONITORING ACTIVITIES

A. Ongoing Monitoring

MCPs are subject to a quarterly monitoring process by DHCS that reviews additional activities, including but not limited to:

- Timely access surveys;

- Investigation of complaints, grievances, appeals, and issues of non-compliance;[67]
- A random sample of the MCP network provider annual network assessments;
- Quality of care indicators;
- Provider to member ratios; and
- OON requests.

In conjunction with the quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying encounter and provider data quality. Encounter and provider data quality metrics include, but are not limited to, primary source verification that is conducted by DHCS' External Quality Review Organization (EQRO) through encounter data validation studies and provider surveys, respectively. In addition, MCPs are subject to a mandatory network adequacy validation performed by the EQRO. The EQRO will validate the previous 12 months of MCP compliance with network adequacy requirements.[68]

B. Public Reporting

DHCS posts all requested and approved AAS on its website.[69] Additionally, DHCS posts CAP reports, which include the findings of DHCS' ANC evaluation and identifies all MCPs that are under a CAP for failure to comply with network adequacy standards. The MCP's response to the CAP will be posted on the DHCS website. [70] In addition, DHCS submits an annual compliance report to CMS and makes it available on the DHCS website.[71]

C. Policies and Procedures

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures, the MCP must submit its updated policies and procedures to its MCOD contract manager within 30 days of the release of this APL. If an MCP determines that no changes to its policies and procedures are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 30 days of the release of this APL attesting that the MCP's policies and procedures have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

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[67] WIC section 14197(f)(2).
[68] 42 CFR section 438.358(b)(1)(iv).
[69] WIC section 14197(e)(3).
[70] WIC section 14197(f)(3).
[71] 42 CFR section 438.207.

MCPs are ultimately responsible for ensuring members obtain medically necessary covered services from an OON provider if the services cannot be provided by a network provider in accordance with contractual requirements. MCPs are also required to ensure that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities, network providers and subcontractors.

If you have any questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Network Adequacy Standards
Attachment A

Network Adequacy Standards					
Provider Type	Timely Access Standard	Time and Distance Standard by County Size[1]			
		Rural	Small	Medium	Dense
Primary Care (Adult and Pediatric)	Within 10 business days to appt. from request	10 miles and 30 minutes from any member or anticipated member's residence			
Specialty Care[2] (Adult and Pediatric)	Within 15 business days to appt. from request[3]	60 miles and 90 minutes from any member or anticipated member's residence	45 miles and 75 minutes from any member or anticipated member's residence	30 miles and 60 minutes from any member or anticipated member's residence	15 miles and 30 minutes from any member or anticipated member's residence
Obstetrics/Gynecology (OB/GYN) Primary Care	Within 10 business days to appt. from request	10 miles and 30 minutes from any member or anticipated member's residence			
OB/GYN Specialty Care	Within 15 business days to appt. from request	60 miles and 90 minutes from any member or anticipated member's residence	45 miles and 75 minutes from any member or anticipated member's residence	30 miles and 60 minutes from any member or anticipated member's residence	15 miles and 30 minutes from any member or anticipated member's residence
Hospitals	Not Applicable	15 miles and 30 minutes from any member or anticipated member's residence			
Pharmacy	Dispensing of at least a 72-hour supply of covered outpatient drug in an emergency situation	10 miles and 30 minutes from any member or anticipated member's residence			

[1] County Size Category by Population defined in Table 1
[2] Time and Distance Standards apply to the core specialists outlined in Table 2
[3] Timely Access standards apply to all specialists, not only core specialists

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Network Adequacy Standards
Attachment A

Network Adequacy Standards					
Provider Type	Timely Access Standard	Time and Distance Standard by County Size[1]			
		Rural	Small	Medium	Dense
Mental Health (non-psychiatry) Outpatient Services[4] (Adult and Pediatric)	Within 10 business days to apt. from request	60 miles and 90 minutes from any member or anticipated member's residence	45 miles and 75 minutes from any member or anticipated member's residence	30 miles and 60 minutes from any member or anticipated member's residence	15 miles and 30 minutes from any member or anticipated member's residence
Ancillary Services	Within 15 business days to appt. from request.	Not Applicable			
Long Term Services and Supports (LTSS)	If applicable[5]	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at the facility for care.			

Table 1: County Size Categories by Population			
Size Category	Population Density	# of Counties	Counties
Rural	≤50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 599 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

[4] Non-specialty mental health services for members with mild to moderate impairments
[5] LTSS Timely Access Network Standards defined in Table 3

Network Adequacy Standards
Attachment A

Table 2: DHCS Adult and Pediatric Core Specialists	
Cardiology/Interventional Cardiology	Nephrology
Dermatology	Neurology
Endocrinology	Oncology
ENT/Otolaryngology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology	Psychiatry
HIV/AIDS Specialists/Infectious Diseases	Pulmonology

Table 3: LTSS Timely Access Network Standards				
Provider Type	Timely Access Standard by County Size			
	Rural	Small	Medium	Dense
SNF	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level			

Table 4: Call Center Wait Time Standards	
Medi-Cal Managed Care Health Plan (MCP) Call Center	10 minutes from the time the call is placed.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP serves as the primary vehicle for ensuring collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

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[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

When a CCS-eligible member moves from one county to another, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP, as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program must communicate all resolved disputes in writing to the MCP. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Consider Ratification of New Finance Policy and Procedure: MA.3003

Contact

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

Recommended Actions

Recommend ratification of new CalOptima Policy MA.3003: Medicare Shared Risk Pool

Background

CalOptima's OneCare program began operations in January 2006 as a Medicare Advantage Special Needs Plan to serve low-income seniors and persons with disabilities. The OneCare Connect program was launched in July 2015 to serve dual eligible members in Orange County by integrating their Medicare and Medi-Cal benefits in order to streamline and simplify access to quality health care services.

As part of CalOptima's arrangement to serve our OneCare and OneCare Connect members, CalOptima and each shared risk health network established Shared Risk Pools in order to share the risk for the cost of caring for these members. CalOptima reconciles the Shared Risk Pool with each of the health networks on an annual basis.

Discussion

CalOptima establishes new and modifies existing policies and procedures to implement federal and state laws, regulations, contracts, and business practices. In addition, CalOptima staff performs an annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

Staff recommends ratification of a new CalOptima Policy MA.3003: Medicare Shared Risk Pool with an effective date of January 1, 2021. This policy formalizes an existing process for CalOptima's administration of the shared risk pools with shared risk group (SRG) health networks for CalOptima's OneCare and OneCare Connect programs and is consistent with the OneCare and OneCare Connect Shared Risk Health Network contracts. This policy currently applies to both the OneCare and OneCare Connect programs. As the State of California plans to discontinue its Cal MediConnect (OneCare Connect) pilot program in conjunction with the CalAIM initiative by the end of December 2022, Staff plans to update this policy in the future so that it will only apply to the OneCare program.

Fiscal Impact

The recommended action to ratify CalOptima Policy MA.3003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation
The recommended action will enhance the efficiency of CalOptima's operations and governance and ensure compliance with applicable regulatory requirements.

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

Attachments
1. CalOptima Policy MA.3003: Medicare Shared Risk Pool

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Policy:	MA.3003
Title:	**Medicare Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2021
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for CalOptima's administration of a Medicare Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima shall establish the Medicare Shared Risk Pool for the Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima shall establish the Medicare Shared Risk Pool each calendar year (CY) during the term of the Shared Risk Group's Contract for Health Care Services.

C. Medicare Shared Risk Budget. The Medicare Shared Risk Budget shall be established based on the Medicare Hospital Budget allocated for Members assigned to the Shared Risk Group within the applicable period.

D. Medicare Shared Risk Expenses. The Medicare Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) claims for Shared Risk Services; and

3. Deduction for any recoveries related to Shared Risk Services, including but not limited to copayments, overpayment recoveries and coordination of benefit recoveries.

E. Quarterly Medicare Shared Risk Reporting. CalOptima shall report the status of the Medicare Shared Risk Pool to its corresponding Shared Risk Group within thirty (30) calendar days following the end of each quarter as follows:

1. Period Ending January 1 to March 31: Due April 30.

2. Period Ending January 1 to June 30: Due July 31.

3. Period Ending January 1 to September 30: Due October 31.

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4. Period Ending January 1 to December 31: Due January 31.

F. Annual Medicare Shared Risk Reconciliation and Settlement. By April 30, CalOptima shall distribute an annual report of the Medicare Shared Risk Program for the preceding CY to the Shared Risk Group. Upon an acceptance of the annual report from the Shared Risk Group, CalOptima shall settle the Medicare Shared Risk Pool for:

1. Surplus. If Medicare Shared Risk Expenses are less than Medicare Shared Risk Budget, CalOptima shall pay a Shared Risk Group an amount equal to fifty percent (50%) of that surplus, less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

2. Deficit. If Medicare Shared Risk Expenses exceed Medicare Shared Risk Budget, CalOptima shall carry forward an amount equal to fifty percent (50%) of that deficit, up to an amount not to exceed $5.00 per Enrollee per month calculated on CY basis, into the next annual reconciliation, along with any additional deficits carried forward from the previous annual settlement.

G. In the event that CalOptima or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima shall settle the Medicare Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.C. of this Policy. If the Medicare Shared Risk Pool settlement calculation results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

H. Upon identification of a payment error, the Shared Risk Group must submit a written notification on a timely basis in order for CalOptima to seek necessary provider recoupment. CalOptima cannot request recoupment from a provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima's original claims payment.

I. If the Shared Risk Group identifies an overpayment of an annual settlement payment, the Shared Risk Group shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima's Accounting Department in writing of the reason for the overpayment. CalOptima shall coordinate with the Shared Risk Group on the process to return the overpayment.

III. PROCEDURE

A. Quarterly Medicare Shared Risk Reporting

1. Within thirty (30) calendar days following the end of each quarter, as detailed in section II.F. of this Policy, CalOptima shall provide the Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The quarterly report shall estimate the projected Medicare Shared Risk Budget, Expenses, and Surplus or Deficit as described in sections II.C., D., and E. of this Policy, for the reporting period.

B. Annual Medicare Shared Risk Reconciliation and Settlement

1. No later than April 30 of each year, CalOptima shall provide the Shared Risk Group with an annual report. The annual report shall show the status of the Medicare Shared Risk Pool for the immediately preceding CY.

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2. CalOptima shall compute the annual Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in sections II.C., D. and, E. of this Policy.

3. Each annual report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima shall refresh the annual report at the time of the following Shared Risk Period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed annual Shared Risk Program report should not contain IBNR and shall be considered final. (e.g., CY2020 Shared Risk Period will be final April 30, 2023).

4. If, upon review of the annual report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the annual report.

   a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the annual report, CalOptima shall settle the Medicare Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, but no later than June 15. Such settlement shall be considered final.

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

   c. CalOptima shall settle the Medicare Shared Risk Pool based on this final annual report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final annual report.

5. If CalOptima determines that a Shared Risk Group has Medicare Shared Risk Pool deficits in two (2) successive fiscal years, or if there is a significant change in risk pool performance, CalOptima may meet with the Shared Risk Group in order to discuss and understand the reason for the pool deficits and develop an improvement plan.

C. Medicare Shared Risk Settlement upon Termination

1. Within one-hundred-twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

2. CalOptima shall compute the Final Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in Section II.C., D. and, E. in accordingly.

3. The Final Reconciliation and Settlement Report shall include refreshed reports from the previous two (2) annual shared risk periods. Or, CalOptima shall refresh any annual report which otherwise would not be considered final as of the effective date of termination of the Contract for Health Care Services with the Shared Risk Group.

4. If, upon review of the Final Reconciliation and Settlement Report, the terminated Shared Risk Group objects to the calculations and determination, the terminated Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation

to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Final Reconciliation and Settlement Report.

a. If CalOptima does not receive any written objection from the terminated Shared Risk Group within thirty (30) calendar days of receipt of the Final Reconciliation and Settlement Report, CalOptima shall settle the Medicare Shared Risk Pool within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final. If the settlement calculation from the Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

b. If CalOptima receives written notice of objection from the terminated Shared Risk Group within the objection period, CalOptima shall re-evaluate its calculations based on additional documentation provided by the terminated Shared Risk Group and provide a revised Final Reconciliation and Settlement Report to the terminated Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

c. CalOptima shall settle the Medicare Shared Risk Pool based on this revised Final Reconciliation and Settlement Report within fifteen (15) calendar days after the date of issuance of the revised Final Reconciliation and Settlement Report. If the settlement calculation from the revised Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

IV. ATTACHMENT(S)

A. Risk Pool Claims Objection Form

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. Medicare Physician Group Service Agreement
C. CalOptima Policy FF.2003: Coordination of Benefits

VI. REGULATORY AGENCY APPROVAL(S)

None To Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2021	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters.
Contracted CalOptima Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide hospital services to CalOptima Direct Members.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare / OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Medicare Hospital Budget	The amount equal to the Non-Part D related capitation that CalOptima receives from Center for Medicare & Medicaid Services (CMS) for Members assigned to the Shared Risk Physician multiplied by Hospital Budget percentage set forth in the Shared Risk Group Contract for Health Care Services.
Medicare Shared Risk Pool	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.
Member	A beneficiary enrolled in a CalOptima program.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, health maintenance organization, Health Network, physician group or other person or institution that furnishes Covered Services.
Shared Risk Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.
Shared Risk Services	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.

1

Hospital Shared Risk Pool
Shared Risk Group: _____
Risk Pool Period
Date of Service: _____
Date of Payment: _____

Line Of Business
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect

Item #	Payment Question/Issue	CalOptima Claim No.	Member Name	Provider Name	Start Date of Service	End Date of Service	Amount Paid	Date of Payment	Requested Credit	CalOptima Review	2nd Level CalOptima GARS Appeal Review	CalOptima Potential Claim Overpayment
							$ -		$ -			$ -

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

14. Consider Approval of Modifications to Policy GG.1900: Behavioral Health Services, to Support the Administration of Behavioral Health Services for CalOptima Medi-Cal Members

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714)246-8887
Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Approve recommended modifications to CalOptima Policy GG:1900: Behavioral Health Services, in accordance with CalOptima's regular review process and consistent with regulatory requirements.

Background

CalOptima staff regularly reviews agency Policies and Procedures to ensure they are up to date and aligned with Federal and State health care program requirements, contractual obligations, and laws, as well as CalOptima operations. CalOptima is also obligated to comply with the Department of Health Care Services (DHCS) Medi-Cal contractual provisions and All Plan Letter (APL) guidance for outpatient mental health services.

CalOptima Policy GG.1900: Behavioral Health Services outlines CalOptima covered Medi-Cal behavioral health benefits, access to care, CalOptima Behavioral Health Line, care coordination, and emergency services. Policy GG.1900 was first made effective in January 2014 to support the implementation of outpatient mental health services for mild to moderate mental health condition.

Discussion

In September 2020, covered Psychological Services described in the Medi-Cal Provider Manual was updated to include Family therapy as a reimbursable service. Family therapy must be composed of at least two family members and is covered for adults with mental health conditions and children, under the age of 21, who meet the Medi-Cal criteria. Policy GG.1900 has been modified to support the updates in the Medi-Cal Provider Manual.

Below is a list of substantive changes to the policy, which are reflected in the attached redline.

The list does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

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Modifications Made to Policy GG:1900: Behavioral Health Services:

Policy Section	Proposed Changes	Rationale	Impact of Change
Page 1, Section II.A.6, line 22 Page 2, Section II.F., line 19	Removed "Use Disorder" and replaced with "Abuse"	To be consistent with updated Policy name - GG.1100: Alcohol and Substance Abuse	There is no impact to CalOptima as this change is to update and correct GG.1100 policy title in this policy.
Page 1, Section II.A.7, lines 25-30	Added "Family therapy (composed of two (2) or more family members) for adult Members with a mental health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered."	Per Medi-Cal Provider Manual – Psychological Services (p. 4) and APL 017-18: Medi-Cal Managed Health Care Plan Responsibilities for Outpatient Mental Health Services (pp. 6, 10)	There is no impact as family therapy has been a CalOptima covered mental health service and the policy reflects current practice. The policy was updated to support and the Medi-Cal Provider Manual and further clarify APL requirements.
Page 2, Section II.C., lines 1 & 2	Added "covered by CalOptima"	To clarify CalOptima does not impose limitations on behavioral health services that are more stringent than limitations placed on medical/surgical services that CalOptima authorizes	There is no impact to CalOptima as an additional language was added to clarify that the section refers to medical services covered by CalOptima.

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Policy Section	Proposed Changes	Rationale	Impact of Change
Page 3, Section II.M.2.b, line 20-21	Changed the sentence from "with the Behavioral Health Vendor's Provider Network" to "within the CalOptima Behavioral Health network."	To clarify CalOptima contracts directly with behavioral health providers	There is no impact since CalOptima transitioned from Behavioral Health Vendor to CalOptima Behavioral Health network (direct contract) in 2018. Policy was updated to reflect current process.
Page 4, Section III.A.1.a, lines 3 & 4	Inserted DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.	To include the APL number and title	There is no impact to CalOptima as change was to add the number and title of the APL for clarity and reference.
Page 5, Section III.C.1.g, line 21	Added the words "but in no case more than two (2) hours after determining the call is emergent"	To clarify the standard	There is no impact to CalOptima as additional language was added to clarify the turnaround time for emergent calls.
Page 5, Section III.C.1.h, line 24	Added the words "after 24 hours making the determination that the call is urgent"	To clarify the standard	There is no impact to CalOptima as additional language was added to clarify the turnaround time for urgent calls.
Page 6, Section III.D.3.c, lines 51-52	Removed the following language: "c. If applicable, inpatient hospital Provider shall notify a Member's behavioral health Provider after a Member has been admitted and discharged from an inpatient mental health treatment."	Not applicable since CalOptima does not manage inpatient psychiatric care	There is no impact to CalOptima as inpatient psychiatric care is the responsibility of OCHCA Mental Health Plan.

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Policy Section	Proposed Changes	Rationale	Impact of Change
Page 7, Section III.D.3.b, lines 1-4	Added the following language: "b. To facilitate transition of care for Members transiting to or from OCHCA mental health services, CalOptima's PCPs and the outpatient behavioral health Providers treating Members with mental illness shall receive clinical consultation, including consultation on medication from OCHCA."	To clarify how providers will be made aware of members transitioning from OCHCA Mental Health services to CalOptima behavioral health.	There is no impact as CalOptima currently coordinates and facilitates transition of care for mental health services with OCHCA.

Fiscal Impact
The recommended action to approve updates to CalOptima Policy GG.1900 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation
CalOptima staff has updated GG.1900 to ensure that it reflects the current Medi-Cal covered behavioral health benefits. The updated policies and procedures will supersede prior versions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy GG.1900: Behavioral Health Services (Redline and Clean versions)
2. Medi-Cal Provider Manual – Psychological Services
3. All Plan Letter (APL) 17-018; Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Policy:	GG.1900
Title:	**Behavioral Health Services**
Department:	Medical Management
Section:	Behavioral Health Integration
CEO Approval:	/s/
Effective Date:	01/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy ~~ensures~~describes access to Behavioral Health Services for Medi-Cal Members.

II. POLICY

A. CalOptima shall provide the following Behavioral Health Services ~~as defined by the Department of Health Care Services (DHCS),~~ when they are provided or ordered by a licensed health care professional~~s~~ acting within the scope of his or her license:

1. Individual/group mental health evaluation and treatment (psychotherapy);
2. Psychological testing when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation for medication management;
5. Outpatient laboratory, supplies and supplements; ~~and~~
6. Alcohol Misuse Screening and Counseling (AMSC) for Members who misuse alcohol, in accordance with CalOptima Policy GG.1100: Alcohol and Substance ~~Use Disorder~~Abuse Treatment Services~~.~~; and
7. Family therapy (composed of two (2) or more family members) for adult Members with a mental health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
   a. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.

B. For Members under the age of twenty-one (21), CalOptima shall provide Medically Necessary non-specialty mental health services listed in Section II A. of this Policy, regardless of the severity of the impairment.

C. CalOptima shall not impose quantitative or non-quantitative treatment limitations more stringently on

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covered Behavioral Health Services than are imposed on medical/surgical services covered by CalOptima, in accordance with the parity in mental health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), ~~Section~~Part 438~~.900~~, Subpart K.

D. CalOptima shall use tools mutually agreed upon with Orange County Mental Health Plan, administered by the Orange County Health Care Agency (OCHCA) to assess the Member's disorder, level of impairment, and appropriate care needed.

E. Through a network of licensed mental health care Providers, CalOptima shall provide Behavioral Health Services to Members with mild to moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group mental health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a mental health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

F. CalOptima and its Health Networks' contracted Primary Care Providers (PCPs) shall provide AMSC for Members identified as at-risk of alcohol misuse in accordance with CalOptima Policy GG.1100: Alcohol and Substance ~~Use Disorder~~Abuse Treatment Services.

G. CalOptima and its Health Networks' contracted PCPs shall be responsible for screening and providing mental health services within the scope of their practice.

H. CalOptima shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with CalOptima Policies HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI), HH.3010Δ: Protected Health Information Disclosures Required by Law, and HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations.

I. CalOptima shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with CalOptima Policies HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, and HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information.

J. CalOptima shall ensure timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and CalOptima Policy GG.1600: Access and Availability Standards.

K. If Behavioral Health Services that are the responsibility of CalOptima are unavailable to the Member within the network, CalOptima shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

L. CalOptima shall not require a referral from a PCP or Prior Authorization for an initial mental health assessment performed by a network mental health Provider. In addition, Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with CalOptima Policies GG.1549: Authorization for Psychological Testing for Mental Health Conditions and GG.1548: Authorization ~~for~~and Monitoring of Behavioral Health Treatment (BHT) Services. Prior Authorization requirements shall be in compliance with the requirements for parity in mental health and substance use disorder benefits in Title 42 CFR section 438.910(d).

M. CalOptima shall maintain a twenty-four (24) ~~hour~~hours per day/seven (7) ~~day~~days per week direct telephone line for emergencies during non-business hours for Members to access and for Providers to coordinate care with the CalOptima Behavioral Health Phone Line or emergency room personnel during a crisis.

1. CalOptima shall ensure:

a. Timely access to screening of Members for mild to moderate Behavioral Health Services;

b. Appropriate staffing levels of the call center; and

c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to CalOptima Policy DD.2002: Cultural and Linguistic Services.

2. CalOptima shall ensure its call center staff have relevant knowledge to:

a. Provide information regarding Covered Services;

b. Identify the location, qualifications, and availability of Providers ~~with~~within the CalOptima Behavioral Health ~~Vendor's~~ Provider network;

c. Inform Members of their rights and responsibilities, in accordance with CalOptima Policy DD.2001: Member Rights and Responsibilities;

d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with CalOptima Policies HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance and GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~;

e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~;

f. Access oral interpretation services and written materials in Threshold Languages for Members;

g. Provide information on other community services or resources available to Members; and

h. Educate the Member ~~of~~regarding the procedure and department at CalOptima to contact if the Member would like to change their Health Network or has questions about Health Network options.

N. CalOptima shall identify and refer an eligible Member to the ~~Orange County Health Care Agency (OCHCA)~~OCHCA for the provision of Medi-Cal Specialty Mental Health Services.

O. CalOptima shall identify and refer an eligible Member to the Orange County Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

III. PROCEDURE

A. PCP and Behavioral Health Services

1. For alcohol misuse, a PCP shall:

a. Administer a DHCS-approved screening tool for identifying alcohol misuse in accordance with DHCS All Plan Letter (APL ~~18-014);~~) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.

b. Provide behavioral counseling intervention on identified issue(s); and

c. Refer a Member to the Orange County DMC-ODS for additional assessment and counseling.

2. For mental health, a PCP shall:

a. Screen and provide mental health services within the scope of their practice; and

b. Refer the Member for further mental health services through CalOptima's Mental Health Provider Network, or the OCHCA.

B. Accessing CalOptima Behavioral Health Services

1. A Member may access Behavioral Health Services through the CalOptima Behavioral Health Phone Line.

2. A Member may be referred to the CalOptima Behavioral Health Phone Line from the following:

a. OCHCA's Orange County Mental Health Plan (OCMHP) Access Line;

b. Self-referral;

c. Authorized Representative or caregiver;

d. PCP;

e. Specialty Care Provider;

f. Behavioral health specialist;

g. Long-Term Support Services (LTSS) Provider;

h. Community-based agency;

i. Case manager, Disease Management staff, or discharge planner; and

j. Other Providers of a Member's health care team.

C. CalOptima Behavioral Health Phone Line

1. Call Center requirements shall include:

a. Complying with telephone access standards in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

b. Utilizing linguistic ~~interpreter services, American Sign Language (ASL)~~ interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication;

c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;

i. If the caller is a CalOptima Medi-Cal Member assigned to Kaiser Foundation Health Plan (Kaiser), CalOptima shall refer and provide the caller the Kaiser phone line to access services.

ii. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Orange County Social Services Agency for enrollment information and suggest a community resource for treatment of their described symptoms.

d. Determining if the caller is seeking help for a mental health concern;

e. Screening for crisis and ~~determine~~determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;

f. If a caller's needs are indicated as requiring Emergent or Urgent Services, call center staff shall make a referral to County's Centralized Assessment Team (CAT) or contact the police without delay to prevent further deterioration of the caller's condition;

g. Call center staff must link Emergent calls immediately, ~~not to exceed~~but in no case more than two (2) hours ~~of~~after determining the ~~determination;call~~ is emergent;

h. Call center staff must link urgent calls for services within twenty-~~-~~four (24) hours after making the determination that the call is urgent;

i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to services or the police department, either through verbal or written communication with appropriate agencies; and

j. If the Caller is determined to be a Medi-Cal beneficiary assigned to CalOptima with a mental health need, the call center staff shall conduct a brief telephone clinical screening to verify appropriate level of services.

2. As a result of the brief telephone clinical screening:

a. If it is determined the Member meets mild to moderate need for Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the CalOptima Behavioral Health Network, are currently accepting CalOptima Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to CalOptima Policy GG.1600: Access and Availability Standards.

b. If determined the Member does not meet mild to moderate need for Behavioral Health Services, the clinician shall complete a warm transfer to the OCMHP Access Line where the Member will be screened for Medical Necessity criteria for Specialty Mental Health Services (SMHS), for Seriously and Persistently Mentally Ill (SPMI), or is a child with Serious Emotional Disturbances (SED).

c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to the Orange County DMC-ODS for Drug Medi-Cal services.

~~b~~d. Should it not be possible to assess a Member appropriately during the brief telephone clinical screening, call center staff shall take further steps to ensure the Member is referred to the most appropriate Level of Care (LOC) by referring the Member for a face-to-face evaluation.

3. CalOptima shall ensure the following steps are completed during the Member call:

   a. Member's eligibility status and Health Network assignment shall be verified each time the Member contacts the CalOptima Behavioral Health Phone Line;

   b. A safety screening, the outcome/results of the screening, and if applicable, any resources/Provider referrals that were provided; and

   c. Justification for clinical disposition for services.

D. Care Coordination

1. CalOptima and its Health Networks shall coordinate care for Members enrolled in the Health Homes Program in accordance with CalOptima Policies GG.1350: Health Homes Program (HHP) Member Eligibility and GG.1331: Health Homes Program (HHP) Services and Care Management.

   a. CalOptima and its Health Networks shall ensure compliance with all applicable State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the HHP Program Guide.

   b. CalOptima and a Health Network shall ensure Members are receiving appropriate and coordinated services.

2. CalOptima shall ensure care coordination with OCHCA is addressed at the bimonthly interagency CalOptima/HCA Collaboration Meeting to ensure:

   a. Provision of all Medically Necessary Covered Services; and

   b. Identification and referral of eligible Members to LTSS based on Member's Plan of Care.

   c. When CalOptima is determined to be responsible for covered Behavioral Health Services, CalOptima shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the OCHCA.

   d. Transition of care is provided for Members transiting to or from CalOptima or OCHCA mental health services. OCHCA clinical consultation, including consultation on medications, shall be provided to CalOptima's PCPs who are treating Members with mental illness;

3. Coordination of care for inpatient mental health treatment:

   a. OCHCA ~~will ensure~~requires that inpatient hospital ~~Provider shall~~Providers notify a Member's PCP within twenty-four (24) hours of admission and discharge from an inpatient mental health treatment to arrange for appropriate follow-up services.

   ~~c. If applicable, inpatient hospital Provider shall notify a Member's behavioral health Provider after a Member has been admitted and discharged from an inpatient mental health treatment.~~

b. To facilitate transition of care for Members transiting to or from OCHCA mental health services, CalOptima's PCPs and the outpatient behavioral health Providers treating Members with mental illness shall receive clinical consultation, including consultation on medication from OCHCA.

~~b.~~c. CalOptima and contracted Health Network PCPs and the outpatient behavioral health Provider shall review and update the care plan of the Member as clinically indicated.

4. Pharmacy services

   a. OCHCA will provide the names and qualification of OCHCA's Prescribers to CalOptima; and

   b. CalOptima shall provide procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories.

5. Emergency Services

   a. CalOptima shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission;

   b. CalOptima shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's mental health or medical condition; and

   c. As the County Mental Health Plan, OCHCA ~~shall provide~~provides emergency assessment of the Member's mental health condition.

6. Information Exchange

   a. CalOptima shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.

7. Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Specialty Mental Health Provider; and

8. Members are receiving services from an Orange County and/or Drug Medi-Cal program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. Memorandum of Understanding with the Orange County Health Care Agency
~~B.~~C. CalOptima Policy DD.2001: Member Rights and Responsibilities
~~C.~~D. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~D.~~E. CalOptima Policy GG.1100: Alcohol and Substance ~~Use Disorder~~Abuse Treatment Services
~~E.A. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility~~
F. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
G. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility
~~G.~~H. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
~~H.~~I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~I.~~J. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
K. CalOptima Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
~~J.~~L. CalOptima Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
~~K. CalOptima Policy GG.1548: Authorization for Behavioral Health Treatment (BHT) Services~~
~~L.~~M. CalOptima Policy GG.1600: Access and Availability Standards
~~M.~~N. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~N.~~O. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
~~O.~~P. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI)
~~P.~~Q. CalOptima Policy HH.3010Δ: Protected Health Information (PHI) Disclosures Required by Law
~~Q.~~R. CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
~~R.~~S. CalOptima Policy HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information
~~S.~~T. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
~~T.~~U. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
~~U. Department of Health Care Services Medi-Cal Health Homes Program Guide~~
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
~~W.A. Memorandum of Understanding with the Orange County Health Care Agency~~
W. Department of Health Care Services (DHCS) Medi-Cal Health Homes Program Guide
X. Medi-Cal Provider Manual – Part 2: Psychological Services
~~X.~~Y. Title 9, California Code of Regulations, §§-1810.370(a)(3), 1830.205 and 1830.210
~~Y.~~ Title 22, California Code of Regulations, §-51337
Z.
~~Z.~~AA. Welfare and Institutions Code, §§-14132.03 and 14189
~~AA.~~ Title 42, ~~Chapter IV, Subchapter C~~Code of Federal Regulations, Part 438, Subpart K
BB.
~~BB.~~
CC. Title 42 Code of Federal Regulations §438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/04/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2014	GG.1900	Behavioral Health Services	Medi-Cal
Revised	07/01/2016	GG.1900	Behavioral Health Services	Medi-Cal
Revised	01/01/2018	GG.1900	Behavioral Health Services	Medi-Cal
Revised	11/01/2018	GG.1900	Behavioral Health Services	Medi-Cal
Revised	10/01/2019	GG.1900	Behavioral Health Services	Medi-Cal
Revised	03/01/2020	GG.1900	Behavioral Health Services	Medi-Cal
Revised	TBD	GG.1900	Behavioral Health Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	A ~~request~~review by CalOptima of an adverse benefit determination, which includes one of the ~~Member~~following actions: A. A denial or limited authorization of a requested service, including determinations based on the ~~Member's Authorized Representative,~~type or ~~Provider~~level of service, requirements for ~~review of an Adverse Benefit Determination that involves the delay, modification, denials~~Medical Necessity, appropriateness, setting, or ~~discontinuation~~effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service~~.~~; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or ~~A.~~E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	~~A~~A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009A: Access by Member's Authorized Representative.~~.
Behavioral Health Services	Services which encompass both mental health and substance use disorder services, as covered by CalOptima.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
~~Behavioral Health Vendor~~	~~A Managed Behavioral Health Organization (MBHO) that contracts with CalOptima to provide Covered Behavioral Health Services to Members assigned to various CalOptima Health Networks, excluding Members assigned to Kaiser Foundation Health Plan (Kaiser).~~

Term	Definition
CalOptima Behavioral Health Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours~~/~~ ~~per~~ day/seven (7) days a week) to obtain referrals for all CalOptima Covered Outpatient Mental Health Services. This line has a live operator at all times and telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.
Child with Serious Emotional Disturbance (SED)	Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program ~~effective July 1, 2019~~, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127~~), effective January 1, 2020~~ for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 ~~and~~ as ~~subsequently~~ amended.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Grievance	~~An expression of dissatisfaction about any matter other than an Adverse Benefit Determination Complaint Appeal Member.~~An oral or written expression of dissatisfaction, about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network Covered Services Members Health Network
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.

Term	Definition
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Medically Necessary or Medical Necessity	Reasonable and necessary ~~services~~ Covered Services to protect life, to prevent ~~significant~~ illness or ~~significant~~ disability, ~~or to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury~~.~~, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval ~~to provide specific services or procedures.~~of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

Term	Definition
Protected Health Information (PHI)	Has the meaning ~~given such term in Section 160.103 of Title~~ 45~~,~~ Code of Federal Regulations~~. Individually~~ Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider. ~~Beginning February 2011, Specialty Care Provider will be used in place of Specialist Physician.~~
Specialty Mental Health Services	Rehabilitation services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric ~~Inpatient Hospital Services~~inpatient hospital services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; and ~~5.~~ Early Periodic Screening, Detection, and Treatment (EPSDT) ~~supplemental~~ Specialty Mental Health Services~~; and/or~~ ~~6.~~5. ~~Psychiatric nursing facility services.~~
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely mental health intervention that shall be appropriate to the severity for the condition.

Policy:	GG.1900
Title:	**Behavioral Health Services**
Department:	Medical Management
Section:	Behavioral Health Integration
CEO Approval:	*/s/*
Effective Date:	01/01/2014
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes access to Behavioral Health Services for Medi-Cal Members.

II. POLICY

A. CalOptima shall provide the following Behavioral Health Services when they are provided or ordered by a licensed health care professional acting within the scope of his or her license:

1. Individual/group mental health evaluation and treatment (psychotherapy);
2. Psychological testing when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation for medication management;
5. Outpatient laboratory, supplies and supplements;
6. Alcohol Misuse Screening and Counseling (AMSC) for Members who misuse alcohol, in accordance with CalOptima Policy GG.1100: Alcohol and Substance Abuse Treatment Services; and
7. Family therapy (composed of two (2) or more family members) for adult Members with a mental health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
    a. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.

B. For Members under the age of twenty-one (21), CalOptima shall provide Medically Necessary non-specialty mental health services listed in Section II A. of this Policy, regardless of the severity of the impairment.

C. CalOptima shall not impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by

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CalOptima, in accordance with the parity in mental health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K.

D. CalOptima shall use tools mutually agreed upon with Orange County Mental Health Plan, administered by the Orange County Health Care Agency (OCHCA) to assess the Member's disorder, level of impairment, and appropriate care needed.

E. Through a network of licensed mental health care Providers, CalOptima shall provide Behavioral Health Services to Members with mild to moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group mental health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a mental health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

F. CalOptima and its Health Networks' contracted Primary Care Providers (PCPs) shall provide AMSC for Members identified as at-risk of alcohol misuse in accordance with CalOptima Policy GG.1100: Alcohol and Substance Abuse Treatment Services.

G. CalOptima and its Health Networks' contracted PCPs shall be responsible for screening and providing mental health services within the scope of their practice.

H. CalOptima shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with CalOptima Policies HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI), HH.3010Δ: Protected Health Information Disclosures Required by Law, and HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations.

I. CalOptima shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with CalOptima Policies HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, and HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information.

J. CalOptima shall ensure timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and CalOptima Policy GG.1600: Access and Availability Standards.

K. If Behavioral Health Services that are the responsibility of CalOptima are unavailable to the Member within the network, CalOptima shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

L. CalOptima shall not require a referral from a PCP or Prior Authorization for an initial mental health assessment performed by a network mental health Provider. In addition, Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with CalOptima Policies GG.1549: Authorization for Psychological Testing for Mental Health Conditions and GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services. Prior Authorization requirements shall be in compliance with the requirements for parity in mental health and substance use disorder benefits in Title 42 CFR section 438.910(d).

M. CalOptima shall maintain a twenty-four (24) hours per day/seven (7) days per week direct telephone line for emergencies during non-business hours for Members to access and for Providers to coordinate care with the CalOptima Behavioral Health Phone Line or emergency room personnel during a crisis.

1. CalOptima shall ensure:

a. Timely access to screening of Members for mild to moderate Behavioral Health Services;

b. Appropriate staffing levels of the call center; and

c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to CalOptima Policy DD.2002: Cultural and Linguistic Services.

2. CalOptima shall ensure its call center staff have relevant knowledge to:

a. Provide information regarding Covered Services;

b. Identify the location, qualifications, and availability of Providers within the CalOptima Behavioral Health Provider network;

c. Inform Members of their rights and responsibilities, in accordance with CalOptima Policy DD.2001: Member Rights and Responsibilities;

d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with CalOptima Policies HH.1102: Member Grievance and GG.1510: Appeal Process;

e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and GG.1510: Appeal Process;

f. Access oral interpretation services and written materials in Threshold Languages for Members;

g. Provide information on other community services or resources available to Members; and

h. Educate the Member regarding the procedure and department at CalOptima to contact if the Member would like to change their Health Network or has questions about Health Network options.

N. CalOptima shall identify and refer an eligible Member to the OCHCA for the provision of Medi-Cal Specialty Mental Health Services.

O. CalOptima shall identify and refer an eligible Member to the Orange County Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

III. PROCEDURE

A. PCP and Behavioral Health Services

1. For alcohol misuse, a PCP shall:

a. Administer a DHCS-approved screening tool for identifying alcohol misuse in accordance with DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.

b. Provide behavioral counseling intervention on identified issue(s); and

c. Refer a Member to the Orange County DMC-ODS for additional assessment and counseling.

2. For mental health, a PCP shall:

a. Screen and provide mental health services within the scope of their practice; and

b. Refer the Member for further mental health services through CalOptima's Mental Health Provider Network, or the OCHCA.

B. Accessing CalOptima Behavioral Health Services

1. A Member may access Behavioral Health Services through the CalOptima Behavioral Health Phone Line.

2. A Member may be referred to the CalOptima Behavioral Health Phone Line from the following:

a. OCHCA's Orange County Mental Health Plan (OCMHP) Access Line;

b. Self-referral;

c. Authorized Representative or caregiver;

d. PCP;

e. Specialty Care Provider;

f. Behavioral health specialist;

g. Long-Term Support Services (LTSS) Provider;

h. Community-based agency;

i. Case manager, Disease Management staff, or discharge planner; and

j. Other Providers of a Member's health care team.

C. CalOptima Behavioral Health Phone Line

1. Call Center requirements shall include:

a. Complying with telephone access standards in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

b. Utilizing linguistic interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication;

c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;

i. If the caller is a CalOptima Medi-Cal Member assigned to Kaiser Foundation Health Plan (Kaiser), CalOptima shall refer and provide the caller the Kaiser phone line to access services.

ii. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Orange County Social Services Agency for enrollment information and suggest a community resource for treatment of their described symptoms.

d. Determining if the caller is seeking help for a mental health concern;

e. Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;

f. If a caller's needs are indicated as requiring Emergent or Urgent Services, call center staff shall make a referral to County's Centralized Assessment Team (CAT) or contact the police without delay to prevent further deterioration of the caller's condition;

g. Call center staff must link Emergent calls immediately, but in no case more than two (2) hours after determining the call is emergent;

h. Call center staff must link urgent calls for services within twenty-four (24) hours after making the determination that the call is urgent;

i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to services or the police department, either through verbal or written communication with appropriate agencies; and

j. If the Caller is determined to be a Medi-Cal beneficiary assigned to CalOptima with a mental health need, the call center staff shall conduct a brief telephone clinical screening to verify appropriate level of services.

2. As a result of the brief telephone clinical screening:

a. If it is determined the Member meets mild to moderate need for Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the CalOptima Behavioral Health Network, are currently accepting CalOptima Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to CalOptima Policy GG.1600: Access and Availability Standards.

b. If determined the Member does not meet mild to moderate need for Behavioral Health Services, the clinician shall complete a warm transfer to the OCMHP Access Line where the Member will be screened for Medical Necessity criteria for Specialty Mental Health Services (SMHS), for Seriously and Persistently Mentally Ill (SPMI), or is a child with Serious Emotional Disturbances (SED).

c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to the Orange County DMC-ODS for Drug Medi-Cal services.

d. Should it not be possible to assess a Member appropriately during the brief telephone clinical screening, call center staff shall take further steps to ensure the Member is referred to the most appropriate Level of Care (LOC) by referring the Member for a face-to-face evaluation.

3. CalOptima shall ensure the following steps are completed during the Member call:

a. Member's eligibility status and Health Network assignment shall be verified each time the Member contacts the CalOptima Behavioral Health Phone Line;

b. A safety screening, the outcome/results of the screening, and if applicable, any resources/Provider referrals that were provided; and

c. Justification for clinical disposition for services.

D. Care Coordination

1. CalOptima and its Health Networks shall coordinate care for Members enrolled in the Health Homes Program in accordance with CalOptima Policies GG.1350: Health Homes Program (HHP) Member Eligibility and GG.1331: Health Homes Program (HHP) Services and Care Management.

a. CalOptima and its Health Networks shall ensure compliance with all applicable State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the HHP Program Guide.

b. CalOptima and a Health Network shall ensure Members are receiving appropriate and coordinated services.

2. CalOptima shall ensure care coordination with OCHCA is addressed at the bimonthly interagency CalOptima/HCA Collaboration Meeting to ensure:

a. Provision of all Medically Necessary Covered Services; and

b. Identification and referral of eligible Members to LTSS based on Member's Plan of Care.

c. When CalOptima is determined to be responsible for covered Behavioral Health Services, CalOptima shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the OCHCA.

d. Transition of care is provided for Members transiting to or from CalOptima or OCHCA mental health services. OCHCA clinical consultation, including consultation on medications, shall be provided to CalOptima's PCPs who are treating Members with mental illness;

3. Coordination of care for inpatient mental health treatment:

a. OCHCA requires that inpatient hospital Providers notify a Member's PCP within twenty-four (24) hours of admission and discharge from an inpatient mental health treatment to arrange for appropriate follow-up services.

b. To facilitate transition of care for Members transiting to or from OCHCA mental health services, CalOptima's PCPs and the outpatient behavioral health Providers treating Members

with mental illness shall receive clinical consultation, including consultation on medication from OCHCA.

c. CalOptima and contracted Health Network PCPs and the outpatient behavioral health Provider shall review and update the care plan of the Member as clinically indicated.

4. Pharmacy services

a. OCHCA will provide the names and qualification of OCHCA's Prescribers to CalOptima; and

b. CalOptima shall provide procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories.

5. Emergency Services

a. CalOptima shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission;

b. CalOptima shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's mental health or medical condition; and

c. As the County Mental Health Plan, OCHCA provides emergency assessment of the Member's mental health condition.

6. Information Exchange

a. CalOptima shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.

7. Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Specialty Mental Health Provider; and

8. Members are receiving services from an Orange County and/or Drug Medi-Cal program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. Memorandum of Understanding with the Orange County Health Care Agency
C. CalOptima Policy DD.2001: Member Rights and Responsibilities

D. CalOptima Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Policy GG.1100: Alcohol and Substance Abuse Treatment Services
F. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
G. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility
H. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy GG.1510: Appeal Process
K. CalOptima Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
L. CalOptima Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
M. CalOptima Policy GG.1600: Access and Availability Standards
N. CalOptima Policy HH.1101: CalOptima Provider Complaint
O. CalOptima Policy HH.1102: Member Grievance
P. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI)
Q. CalOptima Policy HH.3010Δ: Protected Health Information (PHI) Disclosures Required by Law
R. CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
S. CalOptima Policy HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
W. Department of Health Care Services (DHCS) Medi-Cal Health Homes Program Guide
X. Medi-Cal Provider Manual – Part 2: Psychological Services
Y. Title 9, California Code of Regulations, §§1810.370(a)(3), 1830.205 and 1830.210
Z. Title 22, California Code of Regulations, §51337
AA. Welfare and Institutions Code, §§14132.03 and 14189
BB. Title 42, Code of Federal Regulations, Part 438, Subpart K
CC. Title 42 Code of Federal Regulations §438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/04/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2014	GG.1900	Behavioral Health Services	Medi-Cal
Revised	07/01/2016	GG.1900	Behavioral Health Services	Medi-Cal
Revised	01/01/2018	GG.1900	Behavioral Health Services	Medi-Cal
Revised	11/01/2018	GG.1900	Behavioral Health Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2019	GG.1900	Behavioral Health Services	Medi-Cal
Revised	03/01/2020	GG.1900	Behavioral Health Services	Medi-Cal
Revised	TBD	GG.1900	Behavioral Health Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both mental health and substance use disorder services, as covered by CalOptima.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
CalOptima Behavioral Health Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours per day/seven (7) days a week) to obtain referrals for all CalOptima Covered Outpatient Mental Health Services. This line has a live operator at all times and telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

Term	Definition
Child with Serious Emotional Disturbance (SED)	Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
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Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network Covered Services Members Health Network
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Rehabilitation services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric inpatient hospital services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; and 5. Early Periodic Screening, Detection, and Treatment (EPSDT) Specialty Mental Health Services
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely mental health intervention that shall be appropriate to the severity for the condition.

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Psychological Services

Page updated: September 2020

Eligible Medi-Cal recipients may receive psychological services when medically necessary. The information found in this section does not apply to specialty mental health services delivered by county Mental Health Plans (MHPs). For additional information regarding coverage of mental health services, refer to the *Specialty Mental Health Services* section of this manual. For additional help, refer to the *Psychological Services: Billing Examples* section of this manual.

Eligibility

An adult recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health disorder as defined by the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning. A child recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health condition as defined by the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) or as defined by the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5) regardless of level of severity. Adults and children are also eligible for central nervous system tests and assessments when medically necessary.

Exceptions:

Recipients under age 21 may receive up to five sessions of a combination of individual or family therapy before a mental health diagnosis is required.

Recipients under age 21 who have risk factors for mental health disorders as specified in the "Family Therapy" section below, are eligible for family therapy.

Pregnancy and Postpartum-Related Services

Policy for screening for depression in pregnant or postpartum recipients may be found in the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual.

Pregnant and postpartum women with one or more of the following risk factors for perinatal depression are also eligible for individual and group counseling: a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), certain socioeconomic risk factors such as low income, adolescent or single parenthood, recent intimate partner violence, or mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events. Up to a total of 20 individual counseling (CPT® codes 90832 and 90837) and/or group counseling (CPT code 90853) sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 must be submitted on claims for counseling given to prevent perinatal depression.

For information about other pregnancy-related services, providers may refer to the *Pregnancy: Early Care and Diagnostic Services* section of the appropriate Part 2 manual.

Mental Health Services Delivery Systems

Eligible Medi-Cal recipients may receive Medi-Cal mental health services through all Medi-Cal delivery systems including, but not limited to, Managed Care and fee-for-service delivery systems. Recipients that meet medical criteria for specialty mental health services will receive mental health services via county MHPs.

Mental Health Services

Recipients who are eligible for Medi-Cal mental health services may receive the following:

- Individual and group mental health evaluation and treatment (psychotherapy) rendered by a psychologist, LCSW, LPCC or MFT
- Family therapy rendered by a psychologist, LCSW, LPCC, or MFT
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- Specialty mental health services provided by County Mental Health Plans

Treatment Authorization Requests (TARs) are not required for psychology services for Medi-Cal recipients that meet eligibility criteria for mental health services.

Program Coverage

Medi-Cal covers psychological services only when provided by persons who meet the appropriate requirements specified by the *California Code of Regulations*.

Marriage and family therapist interns, registered associate clinical social workers and psychology assistants may render psychotherapy services under a supervising clinician. The claim must list the intern, associate or assistant's name in the *Additional Claim Information* field (Box 19) or in an attachment, along with the supervising clinician's National Provider Identifier number as the "billing provider."

Psychological services are not covered under the County Medical Services Program (CMSP).

"Service" Defined

"Service" means all care, treatment or procedures provided to a recipient by an individual practitioner on one occasion.

Eligibility Requirements

Providers should verify the recipient's Medi-Cal eligibility for the month of service.

Authorization

A *Treatment Authorization Request* (TAR) is not required for psychological services. Psychological services are covered services when ordered by a primary care physician.

Place of Service Codes

Psychologist, LCSWs, LPCCs and MFTs may only bill Place of Service codes for the following: office, home, outpatient hospital, community mental health center, comprehensive rehabilitation facility, state or local public health clinic, rural health clinic or other.

When using Place of Service code "99" (other), indicate the full name and address of the testing location in the *Additional Claim Information* field (Box 19) or on an attachment and leave the *Service Facility Location Information* field (Box 32) blank.

Family Therapy

Family therapy that is evidence-based or incorporates evidence-based components is reimbursable in an outpatient setting for adults with a mental health condition and for children under age 21 who meet at least one the following criteria:

- The child has a diagnosis of a mental health condition as defined by DSM or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). If DC: 0-5 is used for the diagnosis, the corresponding ICD-10 code, which can be found at www.zerotothree.org, must be entered on the claim form.
- The child under age 21 has a history of at least one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  - Separation from a parent/guardian due to incarceration or immigration
  - Death of a parent/guardian
  - Foster home placement
  - Food insecurity, housing instability
  - Exposure to domestic violence or other traumatic events
  - Maltreatment
  - Severe and persistent bullying
  - Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability

- The child under age 21 has a parent/guardian with one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  - A serious illness or disability
  - A history of incarceration
  - Depression or other mood disorder
  - PTSD or other anxiety disorder
  - Psychotic disorder under treatment
  - Substance use disorder
  - A history of intimate partner violence or interpersonal violence
  - Is a teen parent
- The medical provider suspects a mental health disorder and has referred the recipient under age 21 for evaluation. A specific diagnosis is not required for the first five sessions for recipients under age 21. Claims for these visits must be billed with ICD-10 code F99.

Some examples of evidence-based family therapy are:

- Child-Parent Psychotherapy (ages 0 thru 5)
- Triple P Positive Parenting Program (ages 0 thru 16)
- Parent Child Interactive Therapy (ages 2 thru 12)

Family therapy must be composed of at least two family members. Mental health providers must bill for family therapy using the Medi-Cal ID of only one family member per therapy session for CPT codes 90846, 90847 and 99354. Mental health providers must bill for multiple-family group therapy using the Medi-Cal ID of only one family member per family.

Inpatient Family Therapy

Family therapy is reimbursable on an inpatient basis only for infants hospitalized in a neonatal intensive care unit. Claims for these therapy sessions must be billed with ICD-10 code P96.9.

Billing Newborn Infant Family Therapy with Mother's ID

Family therapy rendered to an infant who has not yet been assigned a Medi-Cal ID number may be billed with the mother's ID for the month of birth and the following month only.

Billing Codes

Reimbursement of family therapy is limited to a maximum of 50 minutes when the patient is not present (CPT code 90846) or a maximum of 110 minutes when the patient is present (CPT code 90847 plus CPT code 99354).

When billing family therapy (CPT codes 90846, 90847, 90849 and 99354), providers should use the appropriate code, based on the following descriptions and direct patient care time frames:

Family Therapy Codes Table

CPT Code	Description
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (with patient present), 50 minutes
90849	Multiple-family group therapy
99354	‹‹Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour››

CPT code 99354 is only reimbursable when billed on the same date of service as CPT code 90847.

CPT codes 90846, 90847, 90849 and 90853 may not be billed on the same day for the same beneficiary.

Group Therapy

Group therapy is defined as counseling of at least two but not more than eight persons at any session. There is no restriction as to the number of Medi-Cal-eligible persons who must be included in the group's composition. For example, if there are five patients in the group, and only one is a Medi-Cal recipient, then Medi-Cal should be billed using CPT code 90853, once per session.

Group therapy sessions of less than one and one-half hours are not reimbursable.

Individual Therapy

Individual therapy is limited to a maximum of one and one-half hours per day by the same provider.

When billing individual psychotherapy (CPT codes 90832, 90837, 90839 and 90840), providers should use the appropriate code, based on the following direct patient care time frames:

‹‹**Individual Psychotherapy Codes Table**››

CPT Code	Description
90832	Psychotherapy, 30 minutes with patient
90837	Psychotherapy, 60 minutes with patent
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis each additional 30 minutes

Case Conference

Case conference allowances (CPT codes 99366 and 99368) are limited to conferences with persons immediately involved in the case or recovery of the client.

Central Nervous System Assessments/Tests

Claims for central nervous system assessments/tests (CPT procedure codes 96105, 96110, 96112, 96113, 96116, 96121, 96130 thru 96133, 96136 thru 96139 and 96146) must include an itemization of the tests performed. Providers must list the tests performed either in the *Additional Claim Information* field (Box 19) or on an attachment.

Claims billed with CPT codes 96105, 96116 and 96121 must include an attachment specifying the amount of time spent completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report

Frequency Limitations/Additional Billing Instructions

Frequency limitations and additional billing instructions apply to the following central nervous system assessments/tests:

‹‹**Central Nervous System Assessments Tests Codes Table**››

CPT Code	Description	Frequency Limits
96105	Assessment of aphasia, per hour.	Two episodes per year (≤3 hours each), any provider. All hours for each episode must be billed on the last day of service.
96110 *	Developmental screening, per standardized instrument	Two per year, any provider
96112	Developmental test administration; first hour	One per year, any provider
96113	Developmental test administration; each additional 30 minutes	One per year, any provider
96116	Neurobehavioral status exam; first hour	One per year, any provider
96121	Neurobehavioral status exam; each additional hour	One per year, any provider
96130	Psychological testing evaluation services; first hour	One per year, any provider
96131	Psychological testing evaluation services; each additional hour	Two per year, any provider

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‹‹Neuropsychological Tests Codes Table››

CPT Code	Description	Frequency Limits
96132 †	Neuropsychological testing evaluation services; first hour	One per year, any provider
96133 †	Neuropsychological testing evaluation services; each additional hour	Two per year, any provider
96136 †	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes	One per year, any provider
96137 †	Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes	Nine per year, any provider
96138 †	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	One per year, any provider
96139 †	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes	Nine per year, any provider
96146 †	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	One per year, any provider

Note: A TAR override is allowed for CPT codes 96105, 96110, 96112, 96113, 96116, 96121 96130 thru 96133, 96136 thru 96139 and 96146.

Medical Necessity Criteria for Neuropsychological Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 thru 96139 and 96146 [when billing for neuropsychological testing]) is considered medically necessary:

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or
- When neuropsychological data can be combined with clinical, laboratory and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient's functional status; or
- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- When there is a need to monitor progression, recovery and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or

- When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or
- When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or
- Assessment of neurocognitive functions in order to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or
- When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.

Neuropsychological testing is not considered medically necessary when:

- The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or
- Used as screening tests given to the individual or general populations; or
- Used as a screening test for Alzheimer's dementia; or
- Administered for educational or vocational purposes that do not inform medical management; or
- Performed when abnormalities of brain function are not suspected; or
- Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or
- Repeated when not required for medical decision making, (for example, to make a diagnosis, or to start or continue rehabilitative or pharmacological therapy); or
- Administered when the patient has a substance abuse background and any one of the following apply:
  - the member has ongoing substance abuse such that test results would be inaccurate, or
  - the member is currently intoxicated; or
- The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member's medical management.

Test Scoring/Written Test Report

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. Claims with a test score or written report code billed without a test administration code will be denied.

When billing Place of Service code “99” (other), the full name and address of the testing location must be documented in the *Additional Claim Information* field (Box 19) or on an attachment or the claim will be denied.

Cognitive Skills Development

When billing for cognitive skills development providers should use HCPCS code G0515 (development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes). The frequency limit is two units (30 minutes) per day, any provider.

Medicare/Medi-Cal Crossovers

If Medicare denies payment because the following requirements are not met, payment will also be denied by Medi-Cal.

Requirements

Medicare covers both psychotherapy and central nervous system assessments/tests. Claims for testing and therapy must first be submitted to Medicare before billing Medi-Cal for Medicare-eligible recipients. When billing Medi-Cal, providers must submit an *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) with the claim for services rendered to a Medicare/Medi-Cal recipient.

Diagnostic Testing Covered by Medicare When Ordered by a Physician

Diagnostic testing performed by a psychologist practicing independently of an institution, agency or physician’s practice is covered by Medicare only when the service is ordered by a physician. When submitting a claim, Medicare requires the psychologist to include a copy of the report sent to the physician who ordered the testing and the name and address of the referring physician.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Refer to the *Preventive Services* section in the appropriate Part 2 manual for more information.
†	Neuropsychological tests require medical necessity as explained in this section.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

ALL PLAN LETTER 17-018
SUPERSEDES ALL PLAN LETTER 13-021

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR OUTPATIENT MENTAL HEALTH SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to explain the contractual responsibilities of Medi-Cal managed care health plans (MCPs) for the provision of medically necessary outpatient mental health services and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). MCPs must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM),that results in mild to moderate distress or impairment[1] of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services[2] to children under the age of 21. This APL also delineates MCP responsibilities for referring to, and coordinating with, county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

This letter supersedes APL 13-021 and provides updates to the responsibilities of the MCPs for providing mental health services. Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061[3] describes existing requirements regarding the provision of SMHS by MHPs, which have not changed as a result of coverage of non-specialty, outpatient mental health services by MCPs and the fee-for-service (FFS) Medi-Cal program. The requirements outlined in Information Notice 16-061 remain in effect.

[1] DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS, medical necessity is less stringent than it is for adults; therefore, children with low levels of impairment may meet medical necessity criteria SMHS (CCR, Title 9 Sections § 1830.205 and §1830.210).
[2] The term "non-specialty" in this context is used to differentiate the mental health services covered and provided by MCPs and the FFS Medi-Cal program from the SMHS covered and provided by MHPs. It is not intended to describe the providers of these services as non-specialist providers.
[3] MHSUDS Information Notices are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

BACKGROUND:

The federal Section 1915(b) Medi-Cal SMHS Waiver[4] requires Medi-Cal beneficiaries needing SMHS to access these services through MHPs. To qualify for these services, beneficiaries must meet SMHS medical necessity criteria regarding diagnosis, impairment, and expectations for intervention, as specified below. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)).

The medical necessity criteria for SMHS can be found in Title 9, California Code of Regulations (CCR), Sections (§) 1820.205 (inpatient)[5]; 1830.205 (outpatient)[6]; and 1830.210 (outpatient EPSDT)[7].

DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differs between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS medical necessity is less stringent than it is for adults, therefore children with low levels of impairment may meet medical necessity criteria for SMHS (Title 9, CCR, §1830.205 and §1830.210), whereas adults must have a significant level of impairment. To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria:

1. Have a condition that would not be responsive to physical health care based treatment; and
2. The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MCP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

Consistent with Title 9, CCR, §1830.205, an adult beneficiary must meet all of the following criteria to receive outpatient SMHS:

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[4] SHMS Waiver Information can be found at: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx

[5] Medical necessity criteria for inpatient specialty mental health services (Title 9, CCR, §1820.205) are not described in detail in this APL, as this APL is primarily focused on outpatient mental health services.

[6] Title 9, CCR, §1830.205

[7] Title 9, CCR, §1830.210

1. The beneficiary has one or more diagnoses covered by Title 9, CCR, §1830.205(b)(1), whether or not additional diagnoses, not included in Title 9, CCR, §1830.205(b)(1) are also present.
2. The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis:
   a. A significant impairment in an important area of life functioning; or
   b. A reasonable probability of significant deterioration in an important area of life functioning.
3. The proposed intervention is to address the impairment resulting from the covered diagnosis, with the expectation that the proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, In addition, the beneficiary's condition would not be responsive to physical health care based treatment.

Prior to January 1, 2014, adult MCP beneficiaries who had mental health conditions but did not meet the medical necessity criteria for SMHS had only limited access to outpatient mental health services, which were delivered by primary care providers (PCPs) or by referral to Medi-Cal FFS mental health providers. DHCS paid MCPs a capitated rate to provide those outpatient mental health services that were within the PCP's scope of practice (unless otherwise excluded by contract). Since January 1, 2014, DHCS adjusted MCP capitation payments to account for expanded outpatient mental health services.

DHCS requires MCPs to cover and pay for mental health services conducted by licensed mental health professionals (as specified in the Psychological Services Medi-Cal Provider Manual[8]) for MCP beneficiaries with potential mental health disorders, in accordance with Sections 29 and 30 of Senate Bill X1 1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013), which added §14132.03 and §14189 to the Welfare and Institutions Code. This requirement, which was in addition to the previously-existing requirement that PCPs offer mental health services within their scope of practice, remains in effect, along with the requirement to cover outpatient mental health services to adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (as assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools agreed upon by both the MCP and MHP) resulting from a mental health disorder (as defined in the current DSM).

[8] The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol_a07.doc

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (CMS-2333-F) that applied certain requirements from the Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110-343, enacted on October 3, 2008) to coverage offered by Medicaid Managed Care Organizations. This included the addition of Subpart K – Parity in Mental Health and Substance Use Disorder Benefits to the Code of Federal Regulations (CFR). The general parity requirement (Title 42, CFR, §438.910(b)) stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. This precludes any restrictions to a beneficiary's access to an initial mental health assessment. Therefore, MCPs shall not require prior authorization for an initial mental health assessment. DHCS recognizes that while many PCPs provide initial mental health assessments within their scope of practice, not all do. If a beneficiary's PCP cannot perform the mental health assessment because it is outside of their scope of practice, they may refer the beneficiary to the appropriate provider.

POLICY:

MCPs continue to be responsible for the delivery of non-SMHS for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current DSM. MCPs shall continue to deliver the outpatient mental health services specified in their Medi-Cal Managed Care contract and listed in Attachment 1 whether they are provided by PCPs within their scope of practice or through the MCP's provider network.

MCPs also continue to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for MCP beneficiaries who require SMHS. The eligibility and medical necessity criteria for SMHS provided by MHPs have not changed pursuant to this policy; SMHS continue to be available through MHPs.

MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, §438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider. An MCP is required to cover the cost of an initial mental health assessment

completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

If further services are needed that require authorization, MCPs are required to follow guidance developed for mental health parity, as follows:

MCPs must disclose the utilization management or utilization review policies and procedures that the MCP utilizes to DHCS, its contracting provider groups, or any delegated entity, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits included in the MCP contract.

MCP policies and procedures must ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- Service type
- Appropriate service usage
- Cost and effectiveness of service and service alternatives
- Contraindications to service and service alternatives
- Potential fraud, waste and abuse
- Patient and medical safety
- Other clinically relevant factors

The policies and procedures must be consistently applied to medical/surgical, mental health and substance use disorder benefits. The plan shall notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for MCPs include making utilization management criteria for medical necessity determinations for mental health and substance use disorder benefits available to beneficiaries, potential beneficiaries and providers upon request in accordance with Title 42, CFR §438.915(a). MCPs must also provide to beneficiaries, the reason for any denial for reimbursement or payment of services for mental health or substance use disorder benefits in accordance with Title 42, CFR, §438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.

MCP Responsibility for Outpatient Mental Health Services
Attachment 1 summarizes mental health services provided by MCPs and MHPs. MCPs must provide the services listed below when medically necessary and provided by PCPs or by licensed mental health professionals in the MCP provider network within their scope of practice:

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

Current Procedural Terminology (CPT) codes that are covered can be found in the Psychological Services Medi-Cal Provider Manual (linked in footnote 8 above).

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

For mild to moderate mental health MCP covered services for adults, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to the county MHP for SMHS when a mental health diagnosis covered by the MHP results in significant impairment;

For beneficiaries under the age of 21, the MCP is responsible for providing medically necessary non-SMHS listed in Attachment 1 regardless of the severity of the impairment. The number of visits for mental health services is not limited as long as the MCP beneficiary meets medical necessity criteria.

At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCP's provider network. Each MCP is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the beneficiary to a mental health provider within the MCP network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with the MHP to assess the beneficiary's disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools must be identified in the MOU between the MCP and MHP, as discussed in APL 13-018.

Pursuant to the EPSDT benefit, MCPs are required to provide and cover all medically necessary services. For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. For children under the age 21, MCPs must provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01 and "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)). However for children under the age 21, MCPs are required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by a MHP.

If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because they do not meet the medical necessity criteria for SMHS, then the MCP is required to ensure the provision of outpatient mental health services as listed in the contract and Attachment 1 of this APL, or other appropriate services within the scope of the MCP's covered services.

Each MCP must ensure its network providers refer adult beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the adult MCP beneficiary has a significant impairment, but the diagnosis is uncertain, the MCP must ensure that the beneficiary is referred to the MHP for further assessment.

The MCPs must also cover outpatient laboratory tests, medications (excluding carved-out medications that are listed in the MCP's relevant Medi-Cal Provider Manual[9]), supplies, and supplements prescribed by the mental health providers in the MCP network, as well as by PCPs, to assess and treat mental health conditions. The MCP may require that mild to moderate mental health services to adults are provided through the MCP's provider network, subject to a medical necessity determination.

The MCP may contract with the MHP to provide these mental health services when the MCP covers payment for these services.

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an MCP beneficiary receiving SMHS. The MCP must coordinate care with the MHP. The MCP is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's provider network.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations, as well as other contract requirements and DHCS guidance, including applicable APLs and Duals Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachments

[9] The provider manual for the Two Plan Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan_z01.doc
The provider manual for the Geographic Managed Care Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc
The provider manual for the County Organized Health Systems can be found at:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/.../mcpcohs_z01.doc
The provider manual for Imperial, San Benito, and Regional Models can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial_z01.doc

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY	**Mild to Moderate Impairment in Functioning** A beneficiary is covered by the MCP for services if he or she is diagnosed with a mental health disorder, as defined by the current DSM[11], resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning: • At an initial health screening, a PCP may identify the need for a thorough mental health assessment and refer a beneficiary to a licensed mental health provider within the MCP's network. The mental health provider can identify the mental health disorder and determine the level of impairment. • A beneficiary may seek and obtain a mental health assessment at any time directly from a licensed mental health provider within the MCP network without a referral from a PCP or prior authorization from the MCP. • The PCP or mental health provider should refer any beneficiary who meets medical necessity criteria	**Significant Impairment in Functioning** An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria: 1. Has an included mental health diagnosis;[12] 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function; 3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning. 4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care based treatment. *Note: For beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels*	**Emergency and Inpatient** A beneficiary is eligible for services if he or she meets the following medical necessity criteria: 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent

[10] SMHS provided by MHP
[11] Current policy is based on DSM IV and will be updated to DSM 5 in the future
[12] As specified in regulations Title 9, Section 1830.205 for adults and Section 1830.210 for those under age 21

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY (continued)	for SMHS to the MHP. • When a beneficiary's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the beneficiary may return to the MCP's network mental health provider. *Note: Conditions that the current DSM identifies as relational problems are not covered (e.g., couples counseling or family counseling.)*	*to correct or ameliorate a mental health condition or impairment.*[13]	or emergency intervention provided in the community or clinic; and; f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.
SERVICES	Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation	• Mental Health Services ○ Assessment ○ Plan development ○ Therapy ○ Rehabilitation ○ Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

[13] Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

The following psychiatric drugs are noncapitated except for HCP 170 (KP Cal, LLC):

Amantadine HCl	Olanzapine Fluoxetine HCl
Aripiprazole	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Asenapine (Saphris)	
Benztropine Mesylate	Paliperidone **(oral and injectable)**
Brexpiprazole (Rexulti)	Perphenazine
Cariprazine	Phenelzine Sulfate
Chlorpromazine HCl	Pimavanserin
Clozapine	Pimozide
Fluphenazine Decanoate	Quetiapine
Fluphenazine HCl	Risperidone
Haloperidol	Risperidone Microspheres
Haloperidol Decanoate	Selegiline (transdermal only)
Haloperidol Lactate	Thioridazine HCl
Iloperidone (Fanapt)	Thiothixene
Isocarboxazid	Thiothixene HCl
Lithium Carbonate	Tranylcypromine Sulfate
Lithium Citrate	Trifluoperazine HCl
Loxapine Succinate	Trihexyphenidyl
Lurasidone Hydrochloride	Ziprasidone
Molindone HCl	Ziprasidone Mesylate
Olanzapine	

These drugs are listed in the Medi-Cal Provider Manual in the following link:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

15. Consider Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

Contacts

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

Recommended Actions

1. Approve extension of reimbursement at a flat rate of $45 per month per temporary teleworker, continuing July 1, 2021 on a month-to-month basis through December 31, 2021 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework due to the COVID-19 pandemic; and
2. Authorize the Chief Executive Officer (CEO) to extend the flat rate reimbursement on a month-to-month basis from July 1, 2021 through December 31, 2021 for employees on temporary telework.

Background

In response to the national emergency resulting from the COVID-19 pandemic and recommendations for social distancing for COVID-19 community mitigation strategies, beginning in late March 2020, state and local agencies began implementing stay-at-home orders to limit professional, social, and community gatherings outside of a list of "essential activities." In order to maintain continuity of essential services and business functions while complying with the social distancing guidelines and a safe work environment for employees, CalOptima management initiated a phased-in deployment of temporary telework for CalOptima staff whose job duties could be performed remotely.

As the circumstances favor the continuation of temporary telework to minimize the number of employees present in CalOptima buildings and to slow the spread of COVID-19 in our community, management believes a delayed and gradual return of employees from temporary telework will be the best option for the safety of CalOptima employees. The temporary telework program has continued since March 2020, and temporary telework is in alignment with regulatory recommendations and guidance by the Centers for Disease Control and Prevention (CDC), the Governor's Industry Guidance, CalOSHA, and the Orange County Health Care Agency (OCHCA). Based on the current circumstances and applicable guidelines, management considered CalOptima's obligations under California Labor Code section 2802 to reimburse employees for reasonable expenses in direct consequence of the performance of their obligations for employees on temporary telework.

At its June 4, 2020 meeting, the Board approved reimbursement at a flat rate of $45 per month, commencing April 1, 2020 through June 30, 2020 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework in response to the public health emergency arising from the COVID-19 pandemic and authorized the CEO to extend the flat rate reimbursement on a month-to-month basis thereafter through December 31, 2020 for employees on temporary telework. At its February 4, 2021 meeting, the board extended this authority June 30, 2021.

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Discussion

Temporary telework was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and approximately 49% of employees are currently on temporary telework, which is in addition to those employees who were already teleworking as part of CalOptima's Telework Program. As temporary telework has evolved from a voluntary program to one that is instrumental in CalOptima's efforts to mitigate the spread of the coronavirus, CalOptima, as an employer, has an obligation to pay for a "reasonable percentage" of necessary business expenses such as internet and cell phone service even if it does not require an employee to incur an extra cost.

While personal cell phone use is discouraged, management recognizes that during these unique circumstances, the use of a personal cell phone might be required on an occasional basis. Management also recognizes that internet costs are not generally covered as a business expense and most employees do not use the internet exclusively for CalOptima business. However, to ensure compliance with reimbursement requirements under the Labor Code during these unique circumstances, management is recommending that employees on temporary telework continue to be reimbursed for a reasonable percentage of these and other necessary business expenses.

Staff has determined that a flat reimbursement rate of $45 per month is a reasonable estimate of the proportional cost of cell phone, internet and other necessary business expenses. Management is requesting Board approval of the extension of the flat rate reimbursement for employees on temporary telework for the months of July 2021 through December 2021, for each month an employee is on temporary telework. Employees who believe they are entitled to additional reimbursement must submit an expense reimbursement request with supporting documentation showing why they believe they should receive additional reimbursement, which will be reviewed on a case-by-case basis.

Fiscal Impact

The fiscal impact for the monthly reimbursement for necessary business expenses of employees on temporary telework for the period of July 1, 2021, through December 31, 2021, is $189,000. Funding for the extension of the flat reimbursement rate on a month-to-month basis is included in the proposed Fiscal Year 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation

Continuing the flat reimbursement rate will ensure compliance with Labor Code section 2802 to provide reimbursement for necessary business expenses as a result of temporary telework and also avoid the administrative burden of evaluating individual requests and potentially making disparate determinations on the appropriate reimbursement amount(s) based on a reasonable percentage(s) for each expense item.

Concurrence

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

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Attachments
None

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16. Consider the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8

Contacts

Emily Fonda, MD, MMM, Chief Medical Officer, (714) 246-8487
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Recommend approval of the continued use of the methodology previously approved for the distribution of OneCare Connect quality withhold payments to contracted Health Networks (including the CalOptima Community Network (CCN)) in Demonstration Years (DY) 2-5 (Calendar Years 2016-2019) for the distribution of such payment for DY 6-8 (Calendar Years 2020-2022).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OCC is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), 3% for Years Three, Four, and Five (calendar years 2017-2019) and 4% for Years Six, Seven, and Eight (calendar years 2020 - 2022). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On June 7, 2018, the CalOptima Board of Directors approved the methodology and disbursement of the DY 2-5 (CY2016 – CY2019) quality withhold that was received from DHCS and CMS and distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY 6-8.

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Discussion

CalOptima began participation in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-8) began in 2016, and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by four percent (4%) in Years Six, Seven, and Eight. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics, such as HEDIS/Star measures, and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withholds back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Quality Withhold Distribution Methodology:

To determine the payment allocation to the Health Networks, staff score each measure and determine HN allocation for payment according to the methodology in the tables below. After each measure is scored by comparing performance against established benchmarks, the health network is assigned quality points based on their performance. These points are added up and a weighted factor is determined for overall performance so that higher performing networks earn a higher share of the allocation. This methodology is similar to how CMS assesses health plan performance nationwide. The final step of payment allocation also considers the HN financial model type (HMO, PHC or SRG) to determine any payments that may be required to affiliated hospitals under the PHC model.

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Health Network Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Measure Performance Points

- Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures
- Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s)
- Minimum denominator of 1% of Total Denominator

Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for the measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Health Network (HN) Allocation = HN Weighted % of Allocation

- **Allocation** = Withhold funds received from CMS
- **HN Weighted Allocation** = HN CMS Revenue * HN Quality Points
- **HN Weighted %** = HN Weighted Allocation / Sum of HN Weighted Allocation

P (professional) = 34.40% * HN Allocation
H (hospital) = 50.90% * HN Allocation

- **HMO: Health Networks are paid for Provider and Hospital.**
- **PHC: Hospital is paid directly by CalOptima.**
- **SRG: Money contributed to SRG pool.**

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provide that "CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." The health networks do not have full accountability for every measure. There are measures for which CalOptima has direct responsibility, while CalOptima shares responsibility with the delegated health networks on some measures.

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- The methodology that staff is proposing for DY 6-8 is unchanged from DY 2-5. The methodology provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.
- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.
- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.

Fiscal Impact

The recommended action is budget neutral to CalOptima. Distributions to health networks, including CCN, will not exceed the amount of Medicare quality withhold funds earned back by CalOptima. There is no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks
2. CMC Extension DY6-8 DRAFT dated March 12, 2019 which stipulates the quality withhold for Demonstration Years 6-8 as 4%.
3. Presentation: OCC Quality Withhold Methodology DY6-8

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the methodology for and the disbursement strategy of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network (CCN).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OCC is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost to members, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (MY2015) quality withhold that was received from DHCS and CMS in October 2017 and

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distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY2-5.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima.

CalOptima proposes the following methodology to distribute earned funds back to contracted health networks:

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Health Network Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Measure Performance Points

- Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures
- Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s)
- Minimum denominator of 1% of Total Denominator

Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provides that "CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval."

- The methodology that staff is proposing for DY2-5 provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). The distribution to a health network will not exceed the amount of funds originally withheld from its capitation. If CMS does not return withheld funds based on performance results, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.
- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.

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- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.
- CalOptima contracts with health networks under various arrangements and the allocation for each health network will depend on the withheld amounts received from CMS and the health network performance on the quality measures benchmarked by CMS.
- Health Network payment will depend on the arrangement with CalOptima. Based on current capitation contract arrangement with health networks for CMS revenue, Health Maintenance Organizations (HMOs) will receive their contractually agreed percentage of the withheld amounts for professional services and for hospital services.
- For Physician Hospital Consortiums (PHCs) however, the Physician side of the PHCs will receive their contractually agreed percentage of the withheld amounts for professional services but CalOptima will pay the contractually agreed percentage for hospital services directly to the hospitals.
- Shared Risk Groups (SRGs) will also receive their contractually agreed percentage of the withheld amounts for professional services but the hospital allocation will be contributed to the SRG pool.

Fiscal Impact

The recommended action is budget neutral to CalOptima. The amount of Medicare quality withhold funds earned back by CalOptima, if any, will be sufficient to fund distributions to health networks and CCN with no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachment
Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader *5/30/2018*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. F. Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact
Richard Bock, MD, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Approve the methodology for and the disbursement of the Year One, OneCare Connect Quality Withhold payment to participating Health Networks.

Background
July 2012 marked the passage of the Coordinated Care Initiative in California. The Coordinated Care Initiative (CCI) aims to integrate the delivery of medical, behavioral, and long term care services while providing a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" members.

Central to the CCI model is care coordination. And a critical piece to the model is the care coordination provided for by the member's primary care provider (PCP) and health network. The CCI is expected to produce greater value by improving health outcomes and containing costs; primarily by shifting clinically appropriate service delivery into the home and community and away from expensive institutional settings.

In order to better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One, 2% for Year Two, and 3% for Year Three. All or a part of the withhold may be earned back based on a methodology developed by DHCS and CMS.

Discussion
CalOptima began to participate in the CCI program on July 1, 2015. Given the delayed start date of the program, the first year of the withhold process will be shortened to reflect services rendered from July 1, 2015 to December 30, 2015.

There are ten quality withhold measures in CCI for Year one. Five of these measures are California-specific and were just released by CMS on July 8, 2015.

- Encounter data
- Getting appointments and care quickly
- Customer service
- Behavioral Health provider participates in care plan development (shared accountability measure, payout shared with county)

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- Documentation of care goals
- Case Management contact with member
- OneCare Connect Member Advisory Council implementation
- Memorandum of understanding with County Mental Health
- Timely completion of Health Risk Assessments
- Physical access work plan

Capitation for both Medi-Cal and Medicare payments to CalOptima will be reduced by one percent (1%) in Year One. These withheld funds can be earned back by CalOptima in the following manner:

- Plan will pass or fail each measure based on benchmarks
- All withhold measures will be weighted equally
- If a measure cannot be calculated due to timing constraints (of the shortened Year one) or enrollment requirements, it will be removed from the total number of withhold measures on which the plan will be evaluated.
- Payout will be based on:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Distribution of Earned Withhold Funds to the Health Networks:
CalOptima's contracts with the networks provides that "CalOptima will allocate to Physician Group, and amout of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima. In addition, since the two Behavioral Health measures are governed by language in the three-way contract regarding shared responsibility with County Mental Health, disbursement for them will be described in a future staff recommendation to the Board after further guidance from the State is released. Similarly, distribution of earned back withhold funds attributable to Community Network membership will be described in a future staff recommendation. As 1% of capitation is withheld from CalOptima, the downstream percent of premium (POP) Medicare capitation payments to Health Networks will be similarly reduced. Taking into consideration the truncated duration of Year One and continuing regulatory refinement of the program, the methodology that staff is proposing for Year One provides that Medicare withhold funds which are earned back by CalOptima will be shared with the Health Networks using the identical POP formula.

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- For example, if CalOptima's revenue is $1,000 per member per month (PMPM), the quality withhold is 1%, and a networks's POP is 35%, the network's capitation will be 35% x $990, which is $346.50 PMPM.

- Assuming CalOptima recoups the full withhold of $10, the network will receive 35%, or $3.50 PMPM.

- Future distribution formulae for Years 2 and 3 may take into account the Health Networks' per cent responsibility for, and the relative performance on, the expanded measure set, but this simpler approach is more appropriate for Year One.

- If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network regardless of their performance on the quality measures.

Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period as well as at the time of distribution.

Fiscal Impact
The recommended action is projected to be budget neutral to CalOptima. Distributions to health networks will not exceed the amount of withheld funds that are earned back.

Rationale for Recommendation
These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
Authorized Signature — **Date**

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March 12, 2019

Dear CMC plans,

Please find below draft contract language regarding the draft extension provisions in the California 3-way contract. This language is not final, and is subject to change based on CMS and DHCS clearance processes. Plans will have the opportunity to comment on this and other 3-way contract language via the usual process of updating the contract. We anticipate the MMP comment period to occur later this spring.

Please don't hesitate to reach out to Gretchen.nye1@cms.hhs.gov if you have any questions related to the below language.

1. Experience Rebate/One-Sided Risk Corridor Draft Contract Language (new section 4.4)

4.4. One-Sided Risk Corridors will be established for Demonstration Years 6-8

4.4.1 General Provisions

4.4.1.1 The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2 Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1 All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2 All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Actual and Adjusted Non-Service Expenditures and Actual and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3 CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3 Allowable Expenditures

4.4.1.3.1 CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.4.3 and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Non-Service Expenditure and Adjusted Non-Service Expenditure data.

4.4.1.3.2 CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the

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Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3 The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties). The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2 One-Sided Risk Corridor Parameters

4.4.2.1 The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

4.4.2.1.1 Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2 Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3 Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.4.2.1.3.1 First Band: The Contractor will retain all of the gains that are equal to or less than three percent (3%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

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4.4.2.1.3.2 Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over three percent (3%) and less than or equal to five percent (5%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with eighty percent (80%) retained by the Contractor and twenty percent (20%) paid to DHCS/CMS.

4.4.2.1.3.3 Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with sixty percent (60%) retained by the Contractor and forty percent (40%) paid to DHCS/CMS.

4.4.2.1.3.4 Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with forty percent (40%) retained by the Contractor and sixty percent (60%) paid to DHCS/CMS.

4.4.2.1.3.5 Fifth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty percent (20%) retained by the Contractor and eighty percent (80%) paid to DHCS/CMS.

4.4.2.1.3.6 Sixth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	Incremental Gain[1]	% Contractor Gain Sharing	% State & CMS Gain Sharing	% CMS Gain Sharing	% State Gain Sharing
Gain Band 1	Gains ≤ 3%	100%	0%	0%	0%
Gain Band 2	Gains >3% and ≤5%	80%	20%	(20%) * (Medicare A/B Percent of Rate)	(20%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >5% and ≤7%	60%	40%	(40%) * (Medicare A/B Percent of Rate)	(40%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >7% and ≤9%	40%	60%	(60%) * (Medicare A/B Percent of Rate)	(60%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >9% and ≤12%	20%	80%	(80%) * (Medicare A/B Percent of Rate)	(80%)*(Medi-Cal Percent of Rate)

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Risk Corridor Band	Incremental Gain[1]	% Contractor Gain Sharing	% State & CMS Gain Sharing	% CMS Gain Sharing	% State Gain Sharing
Gain Band 6	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Bands 6 still results in risk sharing reconciliation for the gain in Gain Bands 2-5.

4.4.3 Risk Sharing Settlement

4.4.3.1 CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

4.4.3.2 Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

2. Quality Withhold Draft Contract Language (Section 4.8.1.3 is updated)

4.8.1.3 The quality withhold will increase to two percent 2% in Demonstration Year 2, three percent 3% for Demonstration Years 3-5 and 4% for Demonstration years 6-8. **See Figure 4.6.**

3. Disenrollment Penalty Draft Contract Language (new section 4.10)

4.10 Medicare A/B Disenrollment Penalty

4.10.1 Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the capitation rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect demonstration and to align incentives for plans to improve quality for all enrollees.

4.10.2 Performance will be evaluated annually using the existing Medicare Part C measure entitled “Members Choosing to Leave Plan.” For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at 1% and up to 2%. Additional detail regarding the methodology will be provided in separate technical guidance.

4.10.3 Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration Year has been determined.

4. Contract Term (Section 5.8.1 is updated)

5.8 Contract Term.

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5.8.1 This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the Readiness Review approval, or the effective date of this Contract.

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OneCare Connect

CalOptima

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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OCC Quality Withhold Current Distribution Strategy

Board of Directors Meeting

June 3, 2021

Emily Fonda, M.D., MMM, Chief Medical Officer

Marie Jeannis, Executive Director, Quality & Population Health Management

Purpose

- Request Board approval to continue the use of current Board approved process for allocating Quality Withhold funds to participating Health Networks for the remainder of the OneCare Connect program (measurement years 2020-2022).
- The current process has been in place since 2015
  - Supports successful implementation of the distribution of the quality withhold dollars.
- The slides that follow describe the Quality Withhold distribution methodology.

OCC Quality Withhold (OCC QW) Overview

- CMS Quality Withhold
  - For the remainder of the OCC QW program, (CY 2020-2022) the quality withhold is 4%

- Withhold money earned back by passing OCC QW measures

Percent of Measures Passed	% Withhold CalOptima Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

- Medi-Cal funds are not included in the withhold program

Measure Scoring

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Health Network Measure Performance Points

- NCQA National Medicaid HEDIS Percentiles
- CMS Star Cut Points
- Minimum denominator of 1% of Total Denominator

Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Measure Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Points per Measure Example

Health Network	Health Network Evaluation Annual Flu Vaccine				Health Plan Evaluation Documentation of Care Goals	Quality Points
	CalOptima Rate: 71% Benchmark: 69%				CalOptima Rate: 51.58% Benchmark: 55%	
	Denom	Rate	Stars	Points		
HN A	100	70	3	1	0	1
HN B	50	77	4	2	0	2
HN C	75	85	5	3	0	3
HN D	1	95	5	0	0	0
1% of Denominator	2.25					

1% of denominator will be utilized to set up the minimum denominator for each measure for scoring and health network eligibility to receive withhold payments.

Health Network Allocation

Health Network Allocation Calculation

Health Network (HN) Allocation = HN Weighted % of Allocation

- **Allocation =** Withhold funds received from CMS
- **HN Weighted Allocation =** HN CMS Revenue * HN Quality Points
- **HN Weighted % =** HN Weighted Allocation / Sum of HN Weighted Allocation

Health Network Allocation Example

Health Network	Quality Points	DY CMS Revenue	Weighted Allocation	Weighted %	Health Network Allocation
HN A	1	$3,000	3,000	30%	$30
HN B	2	$2,000	4,000	40%	$40
HN C	3	$1,000	3,000	30%	$30
HN D	0	$2,000	0	0%	$00
			10,000		$100

HN A Example

(Quality Points) * (DY CMS Revenue) = (Weighted Allocation)
1 * $3,000 = 3,000

(HN Weighted Allocation) / (Total Weighted Allocation) = (Weighted %)
3,000 / 10,000 = 30%

(Weighted %) * (Amount Received from CMS) = (Health Network Allocation)
30% * $100 = $30

Health Network Payment Example

Health Network		HN Allocation	P 34.40%	H 50.90%	SRG Pool 50.90%	HN Payment
HN A	HMO	$30	$10.32	$15.27	---	$25.59
HN B	PHC	$40	$13.76	$20.36	---	$13.76
HN C	SRG	$30	$10.32	---	$15.27	$10.32
		$100				

P (professional) = 34.40% * HN Allocation

H (hospital) = 50.90% * HN Allocation

- HMO: Health Networks are paid for Provider and Hospital.
- PHC: Hospital is paid directly by CalOptima.
- SRG: Money contributed to SRG pool.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Item

17. Consider Authorizing a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, and subject to the California Department of Health Care Services (DHCS) approval, as applicable, to:
    a. Implement a two-year pilot Diabetes Mellitus (DM) program involving a multidisciplinary approach to improving care in poorly controlled diabetics for qualifying CalOptima Community Network (CCN) Medi-Cal members;
    b. Execute a contract with a vendor selected through a Request for Proposal process to provide fresh produce delivery services to DM program participants; and
2. Authorize unbudgeted expenditures in an amount of up to $8.2 million from existing reserves to fund the DM pilot program

Background

Diabetes is a disease caused by too much sugar in the blood that requires a primary care provider's (PCP's) comprehensive care. When diabetes is not managed, it can damage vital organs and lead to various complications. According to Centers for Disease Control and Prevention's 2017 data[1], diabetes is the most expensive chronic condition in the United States, and the total annual expenditures on diabetes treatment was $327 billion.

The high cost of diabetes is not just our nation's story; CalOptima is also seeing the high cost of diabetes for our CCN Medi-Cal members. Based on claims data from July 2019 through June 2020, CalOptima observed that approximately $247 million was spent on diabetic care (refer to Attachment 1). In addition to the enormous total cost, the average annual cost per diabetic member was $20,334, which is approximately four times higher than non-diabetic member's average annual cost.

Food insecurity is "a lack of consistent access to enough food for an active, healthy life and it's an issue that touches people of all ages with all types of diabetes[2]." According to American Diabetes Association, diabetics with food insecurity have a higher risk of developing complications. Diabetes is a complex and challenging disease for members, as well as for their families and society at large. To reduce the risk of complications of diabetes, members need to learn about this complex disease and incorporate a variety of self-management behaviors into their daily lives. In order to better assist this population and facilitate PCP care, CalOptima staff proposes to offer a multidisciplinary approach to assist managing CCN Medi-Cal members with poorly controlled diabetes and their complex treatment regimens. The anticipated start date for the DM program is September 1, 2021. The goals of this new DM program are: 1) lower HbA1c level to avoid complications; 2) reduce emergency department (ED) visits; 3) reduce hospitalization rates; 4) reduce costs for diabetic medications; 5) improve member and provider satisfaction; and 6) optimize

[1] https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm
[2] https://www.diabetes.org/healthy-living/recipes-nutrition/food-insecurity-diabetes

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diabetes medication management during the transition to Medi-Cal Rx. This new DM program is proposed in CalOptima's 2021 Quality Improvement (QI) Program. Through the QI Program, CalOptima aims to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

Discussion

Pharmacist Involvement and Intervention

Literature shows that pharmacists involved in diabetes care and management play a pivotal role in helping members achieve healthier lifestyle goals. This active participation in diabetes care and management requires that the CalOptima pharmacist's role extends to include individual member outreach and provider consultations. CalOptima staff believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. With this new DM program, CalOptima proposes to hire two Clinical Pharmacists to provide various interventions to optimize medical management. The estimated salary and benefit expenses for the two-year pilot period is $854,968.

Health Coach/Registered Dietician Intervention

CalOptima's Population Health Management department's Health Coaches have been providing chronic condition management and coaching for members. With the new multidisciplinary approach, CalOptima proposes to hire two Health Coaches to provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. The estimated salary and benefit expenses for the two-year pilot period is $509,342.

Member Health Rewards Program

Subject to DHCS approval, staff proposes supporting member engagement and compliance by providing members with member health rewards (non- monetary incentives). The non-monetary incentives will be provided as gift cards subjected to DHCS approval.

Based on claims data, staff identified poorly controlled diabetic CCN Medi-Cal members as follows:

- Total diabetic members: 12,200
    - Known poorly controlled (HbA1c > 9%): 985 (almost 9% of total diabetics)
    - Intermediate control (HbA1c >= 8-9%): 714 (almost 6% of total diabetics)
    - Adequate control (HbA1c < 8%): 4,231
    - No HbA1c test (in past 12 months): 6,270
        - Potentially poorly controlled: 564 (9% of untested)
        - Potentially intermediate control: 367 (6% untested)

To encourage all CCN Medi-Cal members with diabetes to regularly monitor their blood sugar levels, staff recommends providing $25 non-monetary health rewards (e.g., gift cards) for those who complete their HbA1c test on an annual basis (eligible once a calendar year).

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For those members with poorly controlled HbA1c levels, staff recommends providing $50 health rewards for reducing HbA1c levels by full 1 percentage point, for example, from HbA1c 10 to 9. (eligible twice a year, totaling up to $100). For the 6,270 members who have not had HbA1c test, there is a possibility that 9% (564) of this population may be identified as poorly controlled based on the trends. There is also a possibility that 6% (367) of this population may be identified as intermediate control based on the trends.

Lastly, staff proposes offering $25 health rewards for those members with adequately maintained HbA1c levels for one year (HbA1c less than 8%).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing these Health Rewards Programs for a two-year period is $1,103,040.

Description	**Amount**
$25 Non-monetary health rewards for HbA1c test completion	$244,000
$50 Health reward to improve HbA1c control by 1%	$210,400
$25 Health reward to maintain adequate control	$84,620
Annual Total	$539,020
Provider/member educational expenses	$25,000
Two-year pilot total	**$1,103,040**

Provider Incentives
For providers, staff plans to promote the existing Board-approved Pay for Value (P4V) CCN Program. The program was approved by the Board of Directors on February 6, 2020 and is currently approved through calendar year 2021 and encourages CCN providers to provide timely preventive health care services, deliver excellent outcomes, and achieve and maintain high levels of member satisfaction. In addition to the P4V program, in order to have successful provider buy-ins, staff proposes providing additional incentives for a year participation in the DM program. The additional incentives would not require provider contract amendments.

Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

To be eligible for these additional rewards:

- Year 1: $150
    - PCP to schedule appointment and see member
    - Order HbA1c lab test
    - PCP to have a consultation with CalOptima pharmacist to review the medication review tool list along with pharmacy recommendations and consider making changes
        - CalOptima Pharmacy documentation of PCP participation
- Year 2: $200
    - If a PCP manages to lower an eligible member's HbA1c < 8%, the PCP would be eligible to receive an additional $200 (one time per member per year).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing provider incentives for a two-year period is $736,400.

Description	**Amount**
Year 1 Provider Incentives	$315,600
Year 2 Provider Incentives	$420,800
Two-year pilot total	**$736,400**

Fresh Produce Delivery Program
Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Subject to DHCS approval, staff proposes including a fresh produce delivery into this new multidisciplinary DM program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our CCN Medi-Cal poorly controlled diabetic members.

In order to qualify for food delivery, members must meet the following requirements:

- Have an appointment with their PCP and have HbA1c lab test
- Lab results indicates that HbA1C >= 8
- Have consultation with CalOptima Pharmacist
- Have consultation with CalOptima Registered Dietician

Qualified members with poorly controlled diabetes will receive fresh produce delivered to their homes twice per month following engagement in the program.

Staff assumes a predicted participation rate of 80%. The total estimated annual cost for implementing the fresh produce delivery program is $ $2,474,304 or $4,948,608 for the two-year period.

Evaluation Goals
During the two-year pilot intervention, staff proposes to review members' progress on a semiannual basis and study the following annually:

Hospitalization rates	Member satisfaction (survey)
% reduction in members with HbA1c >= 8	Provider satisfaction (survey)
Rate of medication adherence	Review pharmaceutical cost savings
Participation rate	ED visits/rates

To measure member and provider satisfaction, staff proposes conducting a before-and-after survey. The estimated mailing cost for conducting a before-and-after survey is $7,500.

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Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $8.2 million from existing reserves will fund this action.

Rationale for Recommendations

The recommended actions will support CalOptima's efforts to assist members with poorly controlled diabetes achieve healthier lifestyles and avoid complications.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Cost Comparison Diabetic vs. Non-Diabetic Members
2. PowerPoint Presentation

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Continued to a Future Meeting

Cost Comparison - Diabetic vs. Non-Diabetic Members

From: 2019-07 Through: 2020-06 For CCN - MC

	Distinct Members		Total Amount Paid		Avg Cost Per Member		% of Population Utilizing Services	
	Diabetic	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**
Grand Total	12,200	69,426	$247,898,668	$370,585,854	$20,320	$5,338	100.0%	100.0%
LTC	340	298	$28,569,377	$25,269,785	$84,028	$84,798	2.8%	0.4%
Inpatient	2,087	6,082	$73,209,011	$97,481,773	$35,079	$16,028	17.1%	8.8%
Hospice	144	273	$1,875,977	$2,465,905	$13,028	$9,033	1.2%	0.4%
Outpatient	7,036	28,775	$41,171,497	$51,745,653	$5,852	$1,798	57.7%	41.4%
Pharmacy	11,821	55,186	$56,199,373	$88,097,684	$4,754	$1,596	96.9%	79.5%
Professional	11,609	64,740	$46,873,433	$105,525,053	$4,038	$1,630	95.2%	93.3%

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Diabetic with HbA1c > 9

*Latest from last 12 months

Total	12,200
HbA1c > 9	985
HbA1c <= 9	4,945
No HbA1c Result	6,270

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CalOptima

Better. Together.

Multidisciplinary Approach to Improve Care in Poorly Controlled Diabetics

Board of Directors Meeting
June 3, 2021

Emily Fonda, MD, MMM
Chief Medical Officer

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Diabetes: Overall Costs

- Seventh leading cause of death in California
- Diabetes and its complications lead to a poor quality of life
- Total cost of diabetes increased 60% from 2007 to 2017
- Total annual national cost of diabetes in 2017 was $327 billion

Sources:

- Centers for Disease Control and Prevention, National Center for Health Statistics & National Center for Chronic Disease Prevention and Health Promotion
- National Center for Biotechnology Information, U.S. National Library of Medicine

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CalOptima A Public Agency

Diabetes: CalOptima Costs

- Total annual cost for diabetes is more than $247 million for Medi-Cal and CalOptima Community Network (CCN)
  - Pharmacy costs more than $56 million
- Care for a diabetic member costs almost four times as much as care for a non-diabetic member
  - Diabetic member: $20,320
  - Non-diabetic member: $5,338

Based on July 2019–June 2020 claims/encounter data.

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CalOptima
A Public Agency

Proposal to Improve Care in Diabetic CCN Members

- Implement a multidisciplinary approach to care for CCN members with poorly controlled diabetes with a goal to lower HbA1c < 8% to reduce complications
  - Poorly controlled diabetics: HbA1c level >9%
- Assist primary care providers (PCPs) by offering:
  - Individual consultations
  - Collaboration with CalOptima pharmacists, health coaches and registered dietitians
  - Referrals to all CalOptima resources, such as case management and transportation
  - Provider incentives
- Motivate and engage members through provision of health rewards and fresh produce delivery

Source: American Diabetes Association, Diabetes Care

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CalOptima
A Public Agency

Proposal Goals and Cost

- Program goals
  - Improve the quality of life for diabetic CCN members
  - Reduce HbA1c levels to < 8% to avoid complications
  - Reduce utilization and medication costs
  - Improve member and provider satisfaction (measure with surveys)
  - Optimize medication management using current formulary
  - Smooth the Medi-Cal pharmacy transition to Medi-Cal Rx
- Estimated cost for two-year pilot: $8.2 million

Sources: American Diabetes Association, Diabetes Care diaTribe

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CalOptima A Public Agency

Intervention: Pharmacist

- Extend CalOptima pharmacist's role to include individual member outreach with consultation
- Consult with PCP
  - Review the medication review tool
  - Offer specific pharmacy recommendations to optimize diabetic management
- Collaborate with the multidisciplinary team
  - PCP, member, health coach, registered dietitian and case manager, as indicated
- Document PCP participation in program

Intervention: Health Coach and Registered Dietitian

- Develop CCN-specific assessments to support the program and care planning
- Conduct motivational interviewing
- Collaborate with the multidisciplinary team
- Support member needs by providing targeted education materials
- Identify other acute needs and connect members to case management or other services
- Refer members to other community resources

Member Health Rewards*

- Support member engagement and compliance
- Recommend health rewards for all diabetics
  - 12,200 members identified with diabetes
    - Anticipate 80% program engagement rate ~4,800
    - $25 reward for completing their annual HbA1c test
  - 2,630 members with intermediate to poorly controlled HbA1c level >= 8%
    - 1,699 known members; 931 potential members with no test
    - $50 reward for reducing HbA1c level by 1%
    - Eligible twice a year for up to $100 for reducing by 2%
  - 4,231 members with HbA1c level < 8% maintained for one year (intermediate to adequate control)
    - $25 reward for maintaining their HbA1c level <8% for one year

*Subject to DHCS approval

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A Public Agency

Provider Incentives for Diabetic Care

- Motivate providers to deliver improved outcomes
  - Separate from Pay for Value Program (P4V)
    - P4V includes comprehensive diabetes care
- PCP incentive eligibility criteria
  - Schedule appointment to see member with poorly controlled diabetes
  - Order HbA1c lab test
  - Consult with CalOptima pharmacist
- Recommended incentives
  - Year 1: $150 per member in the program and completing eligibility criteria
  - Year 2: $200 per member if a PCP manages to lower the member's HbA1c level < 8%

Fresh Produce Delivery Program*

- Diabetics are affected by Social Determinants of Health, such as food insecurity, and have a higher risk of developing complications (per ADA)
- Support access to nutritious food to improve outcomes
- Eligibility criteria
  - Complete appointment with PCP and have HbA1c lab test
  - Receive lab results indicating HbA1c level >= 8%
  - Consult with CalOptima pharmacist
  - Consult with CalOptima registered dietitian
- Qualified members will receive fresh produce delivered to their homes twice per month

*Subject to DHCS approval

Source: American Diabetes Association

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Next Steps

- Obtain the Board's approval to allocate IGT 10 funds
- Collaborate with stakeholder and community partners
- Implement program by September 1, 2021
- Track outcome measures

• Member Satisfaction (Before/After Survey)	• Provider Satisfaction (Before/After Survey)
• ED visits/rates	• Hospitalization rates
• Rate of medication adherence	• Prescription cost savings
• Percent reduction in members with HbA1c level >=8%	• Program participation rate

- Report outcomes to the Board

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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A Public Agency

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

18 Consider Ratifying a Letter of Commitment in Support of the Orange County Health Care Agency Health Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 Grant Application

Contacts

Marie Jeannis, Executive Director, Quality and Population Health Management, (714) 246-8591
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Ratify CalOptima's Letter of Commitment to Support the Orange County Health Care Agency (OCHCA) Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 Grant Application

Background

The Department of Health and Human Services, Office of the Assistant Secretary for Health released a Notice of Funding Opportunity: Advancing Health Literacy to Enhance Equitable Community Response to COVID-19 (Health Literacy Grant) on March 8, 2021, with proposals due on April 20, 2021. The eligible applicants for the grant opportunity include, among others, local county governments. Proposed projects are expected to demonstrate the effectiveness of local evidence-based health literacy strategies that are culturally appropriate to enhance COVID-19 testing, contact tracing and/or other mitigation measures (e.g., vaccination) in racial and ethnic minority populations and other socially vulnerable populations. The initiative must align with, but not duplicate, existing federal efforts to disseminate resources for COVID-19 responses.

The OCHCA advised CalOptima management on March 31, 2021, of its plan to submit an application for $4 million for the Health Literacy Grant to target the needs of seniors with chronic conditions, specifically obesity and diabetes, and the providers serving these individuals. The OCHCA advised CalOptima that most of the funding is expected to be distributed to other community partners, including Council on Aging, Multi-Ethnic Collaborative of Community Agencies (MECCA), Orange County Aging Services Collaborative, and the Orange County Office on Aging.

CalOptima currently has more than 800,000 low-income Orange County residents as members. More than 40% of CalOptima members' primary language is not English, including 27% Spanish and 11% Vietnamese. Other languages with significant representation include Korean, Farsi, Arabic and Chinese. CalOptima's member population includes all ages, with approximately 11% being seniors ages 65 and above.

Utilization and medical diagnoses for members with Medi-Cal Aid Code "Aged" identify diabetes as the second-most prevalent medical condition, affecting 28.7% of this population. In Medi-Cal members 20–64 years, obesity and diabetes rank second and third, affecting 10.5% and 8.7% of members, respectively. Lastly, for Medi-Cal members 65 years and older, diabetes is identified as the second-most prevalent medical condition at 30.4% of the population.

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These members receive care from a robust network of more than 1,500 contracted primary care providers and 7,600 specialists. Members also receive other services to address health care and other services not covered by CalOptima from a variety of other organizations including, for example other Orange County agencies and community-based originations, such as those identified by OCHCA.

CalOptima has existing resources and strategies that align with the OCHCA proposal. For example, CalOptima's Population Health Management (PHM) has a comprehensive plan of action for addressing its culturally diverse member needs across the continuum of care. CalOptima's PHM strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

Discussion

CalOptima supports the intended OCHCA grant activities to improve health literacy to support activities to address the COVID -19 pandemic through existing resources and strategies. The proposed grant activities and Letter of Commitment would promote programs that are consistent with CalOptima's mission, programs, standards, and purpose and are consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name or Logo. CalOptima agreed in the Letter of Commitment that the following three CalOptima programs would be available as more thoroughly described in Attachment 3:

- Health Education: CalOptima's PHM department employs Registered Dieticians and Certified Diabetes Educators along with other health professionals to improve diabetes and obesity management for CalOptima members. Health coaches regularly intervene in-person or telephonically, and provide culturally appropriate support for areas, such as medication adherence, exercise and diet adjustment. The goal is to decrease A1C values and improve other health outcomes.

- Health Materials Validation: CalOptima promotes health literacy by using appropriate resources and educational tools. In accordance with DHCS and CMS requirements, CalOptima has a process for the readability and suitability review and approval of all written member health education materials. The process ensures written materials are age appropriate, at no higher than a sixth-grade reading level, in 12-point or 18-point font depending on visual impairment. Additionally, materials are available in threshold languages that are culturally and linguistically appropriate for the intended audience. CalOptima intends to support OCHCA with validating content created for targeted audiences. Validated content is proven to be effective for ongoing management of members with chronic conditions.

- Provider Training and Education: CalOptima has a long history of providing Continuing Medical Education (CME) opportunities for providers on important subjects that support better care for members. CalOptima will offer CME virtually or in-person on health literacy in diabetes and obesity management for diverse populations to raise awareness and enhance the delivery of providers'

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services. Furthermore, CalOptima also publishes several provider-focused newsletters each year and can routinely include articles focused on health literacy in diabetes and obesity management.

To support OCHCA's timely submission of the Health Literacy Grant application by the April 20, 2021 due date, CalOptima's Chief Executive Officer executed the Letter of Commitment and is now seeking ratification. CalOptima staff plans to return to the Board at a future meeting to seek authority to enter into a Memorandum of Understanding with the County. The grant start date, if awarded, is anticipated to be July 1, 2021.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
CalOptima and OCHCA share common goals of improving care and health outcomes for CalOptima members, including seniors with chronic conditions as well as racial and ethnic minority populations. Ratifying the Letter of Commitment will support the efforts the OCHCA plans to implement along with community partners to improve health disparities, and the proposed grant activities are consistent with CalOptima's mission, programs, standards, and purpose.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. Department of Health and Human Services, Office of the Assistant Secretary for Health, Notice of Funding Opportunity: Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19
3. CalOptima Letter of Commitment

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Council on Aging Southern CA	2 Executive Circle #175	Irvine	CA	92614
Multi-Ethnic Collaborative of Community Agencies (MECCA)	1505 17th Street #123	Santa Ana	CA	92705
Orange County Aging Services Collaborative *(Alzheimer's Orange County is Fiscal Sponsors)*	2515 McCabe Way #200	Irvine	CA	92614
Orange County Health Care Agency	405 W 5th Street	Santa Ana	CA	92701
Orange County Office on Aging	1300 S Grand Avenue Bldg. B	Santa Ana	CA	92705

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Notice of Funding Opportunity: Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19

Opportunity Number:

MP-CPI-21-006

Application Due Date:

April 20, 2021 at 6:00 PM Eastern

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OVERVIEW

FEDERAL AGENCY NAME

Office of the Assistant Secretary for Health / Office of Minority Health

FUNDING OPPORTUNITY TITLE

Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19

ACTION

Notice

ANNOUNCEMENT TYPE

Grant

FUNDING OPPORTUNITY NUMBER

MP-CPI-21-006

ASSISTANCE LISTING NUMBER AND PROGRAM TITLE

93.137 Community Program to Improve Minority Health

DATES

Application Deadline: April 20, 2021 by 6:00 PM Eastern

Technical Assistance: Webinar, March 17, 2021 at 5:00PM Eastern.

EXECUTIVE SUMMARY

The Office of Minority Health announces the availability of funds for Fiscal Year 2021 grants under the authority of 42 U.S.C. § 300u-6 (Section 1707 of the Public Health Service Act) and the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260).

This notice solicits applications for projects to demonstrate the effectiveness of local government implementation of evidence-based health literacy strategies that are culturally appropriate to enhance COVID-19 testing, contact tracing and/or other mitigation measures (e.g., public health prevention practices and vaccination) in racial and ethnic minority populations and other socially vulnerable populations, including racial and ethnic minority rural communities. This initiative will align with, but not duplicate, existing federal efforts to disseminate resources for COVID-19 responses.

Applicant eligibility is limited to localities (e.g., cities, counties, parishes, or other similar subdivisions). OMH encourages applicants to partner with a Minority Serving Institution for

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quality improvement activities and program evaluation. See Appendix G for a list of Minority Serving Institutions, which can also be found here https://www.minorityhealth.hhs.gov/assets/PDF/2020_Minority_Serving_Institutions.pdf.

OMH anticipates the availability of $250,000,000 for this funding opportunity to support awards for up to two years as follows:

- Urban communities: approximately 30 awards, up to $4,000,000 each
- Rural communities: approximately 43 awards, up to $3,000,000 each

HHS/OASH encourages applicants to review all program requirements, eligibility information, application format and submission information, evaluation criteria, and other information in this funding announcement to ensure that its application complies with all requirements and instructions.

FUNDING OPPORTUNITY DETAILS

A. DATES

1. Application Deadlines

Applications are due April 20, 2021 by 6 p.m. Eastern Time.

To receive consideration, you must submit your application electronically via Grants.gov no later than this due date and time. If you do not submit your application by the specified deadline, we will return it to you unread. You must submit electronically via Grants.gov unless you obtain a written exemption from this requirement 2 business days in advance of the deadline from the Director, HHS/Office of the Assistant Secretary for Health (OASH) Grants and Acquisitions Management (GAM) Division. To obtain an exemption, you must request one via email from the HHS/OASH/GAM and provide details as to why you are technologically unable to submit electronically through Grants.gov. Your request should be submitted at least 4 business days prior to the application deadline to ensure your request can be considered prior to 2 business days in advance of the deadline. If you request an exemption, include the following in your e-mail request: the HHS/OASH announcement number; your organization's DUNS number; your organization's name, address and telephone number; the name and telephone number of your Authorizing

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Official; the Grants.gov Tracking Number (for example, GRANT####) assigned to your submission; and a copy of the "Rejected with Errors" notification from Grants.gov. Send the request with supporting documentation to OASH_Grants@hhs.gov.

Note: failure to have an active System for Account Management (SAM) registration prior to the application due date will not be grounds for receiving an exemption to the electronic submission requirement. As a result of the public health emergency for COVID-19, the requirement for an active SAM registration at the time of application submission has been waived (see Section F.4). However, if you do not have a DUNS number at this time, you should contact the Grants.gov to establish a temporary DUNS number. Your application will not be accepted through Grants.gov without this number. Failure to follow Grants.gov instructions to ensure software compatibility will not be grounds for receiving an exemption to the electronic submission requirement.

The HHS/OASH GAM will only accept applications via alternate methods (hardcopy paper via U.S. mail or other provider or PDF via email) from applicants obtaining prior written approval. If you receive an exemption, you must still submit your application by the deadline. Only applications submitted through the Grants.gov portal or alternate format (hardcopy paper via U.S. mail or other service or PDF via email) with an approved written exemption will be accepted. *See* Section F.8 ("Other Submission Requirements") for information on application submission mechanisms.

Executive Order 12372 comment due date: The State Single Point of Contact (SPOC) has 60 days from the application due date to submit any comments. For more information on the SPOC see section F.6 Intergovernmental Review.

To ensure adequate time to submit your application successfully, HHS/OASH recommends that you register as early as possible in Grants.gov since the registration process can take up to one month. You must register an authorizing official for your organization. HHS/OASH does not determine your organization's authorizing official; your organization makes that designation. For information on registering for Grants.gov, refer to http://www.grants.gov or contact the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding holidays) at 1-800-518-4726 or support@grants.gov.

Your organization is strongly encouraged to register multiple authorized organization representatives in Grants.gov to ensure someone is available to submit your application.

2. Technical Assistance

A technical assistance webinar for potential applicants will be held March 17, 2021 at 5:00 pm Eastern. Login details will be posted at https://minorityhealth.hhs.gov.

We recommend you review the entire announcement promptly so you can have any questions answered well in advance of the application due date. We also recommend you subscribe to this announcement in Grants.gov so you receive any amendments, question and answer documents, or other updates.

B. PROGRAM DESCRIPTION

The Office of the Assistant Secretary for Health (OASH) and the Office of Minority Health (OMH) announce the availability of funds for Fiscal Year (FY) 2021 under the authority of 42 U.S.C. § 300u-6 (Section 1707 of the Public Health Service Act) and the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260). OMH is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. Through its demonstration grants, OMH supports the identification of effective approaches for improving health outcomes with the ultimate goal of promoting dissemination, adoption and sustainability of these approaches. The Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 initiative aligns with: (1) HHS Strategic Plan Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play; (2) Healthy People 2030 objectives: (a) HC/HIT-01: Increase the proportion of adults whose health care provider checked their understanding; (b) HC/HIT-02: Reduce the proportion of adults who report poor patient and provider communication; (c) HC/HIT-03: Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted; and (d) IID-D02: Increase the proportion of people with vaccination records in an information system; and (3) the OASH priority on health disparities (1, 2). OMH will consider the following additional factors when making recommendations for funding, listed below in no particular order:

- Applicants serving localities with the highest social vulnerability. This may be determined by being in the top 4th as defined by the CDC's Social Vulnerability Index (SVI) county maps at

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https://svi.cdc.gov/prepared-county-maps.html, or alternate similar data source if SVI is not available.

- Applicants with identified Minority Serving Institution partners. **Minority Serving Institutions** are defined by the U.S. Department of Education as a category of institutions of higher education enrolling populations with significant percentages of undergraduate minority students, or that serve certain populations of minority students under various programs created by Congress. Find the full definition and list of Minority Serving Institutions here: https://www2.ed.gov/about/offices/list/ocr/edlite-minorityinst.html. See Appendix G for a list of Minority Serving Institutions, which can also be found here https://www.minorityhealth.hhs.gov/assets/PDF/2020_Minority_Serving_Institutions.pdf.

- Equitable geographic distribution.

1. Background

This initiative is based on data demonstrating COVID-19 disparities among racial and ethnic minority populations. According to national data from the Centers for Disease Control and Prevention (CDC), among those tested for COVID-19, non-Hispanic Black, Hispanic or Latino, and non-Hispanic people who identify as more than one race were more likely to have positive test results compared with non-Hispanic white or non-Hispanic Asian people (3).

The disparities associated with the COVID-19 pandemic have shown the importance of improving health literacy related to COVID-19 within racial and ethnic minority populations. Researchers have described a conceptual model explaining the well-established association between limited health literacy and health outcomes (4). Individuals with low health literacy have been reported to have higher rates of emergency room visits and hospitalizations, worse preventive care and health outcomes for children, and increased mortality compared with individuals with higher health literacy (5). Researchers have reported that health literacy likely is a factor impacting adherence to COVID-19 mitigation strategies (6), and Healthy People 2030 notes that low or limited health literacy skills are more prevalent among certain population groups (e.g., racial and

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ethnic minority populations and limited English proficient individuals). Evidence shows that lower access to information about COVID-19 (e.g., disease rates at a local level, opportunities for testing and treatment, and behavior that may modify disease risk) among racial and ethnic minority populations effects individual decision-making and health behavior during the pandemic (6). Thus improving health literacy on COVID-19, which includes increasing access to culturally and linguistically appropriate health information, can contribute to improved responses to public health strategies for COVID-19 and related health outcomes among racial and ethnic minority populations. Refer to Appendix C and Appendix D for more information, resources and tools related to health literacy.

2. Expectations

a. Disparity impact and health equity promotion

OMH expects recipients to develop a disparity impact statement using local data (e.g., the CDC Social Vulnerability Index (SVI) https://www.atsdr.cdc.gov/placeandhealth/svi/index.html) to identify racial and ethnic minority populations at highest risk for health disparities, low health literacy and not being engaged or reached through existing public health messages and approaches for promoting COVID-19 public health recommendations (e.g., for testing, contact tracing, vaccination and other efforts to mitigate the impact of the virus). The disparity impact statement will provide the framework for ongoing monitoring and determining the impact of the health literacy interventions on adherence to COVID-19 public health recommendations. See Appendix E – Disparity Impact Statement for details and resources.

b. Health literacy plan implementation and sustainability

OMH expects recipients to develop and implement a health literacy plan, that incorporates the National CLAS Standards, to increase the availability, acceptability and use of COVID-19 public health information and services by racial and ethnic minority populations and others considered vulnerable for not receiving and using COVID-19 public health information. The health literacy interventions included in the plan also should promote changes in the healthcare delivery system broadly that advance Healthy People objectives HC/HIT-01, HC/HIT-02 and HC/HIT-03 (improve understanding, communication, informed decision-making). The health literacy plan will provide guidance for new and/or revised policies for improving and sustaining adherence to COVID-19 and other public health recommendations, using evidence-based and culturally and

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linguistically appropriate health literacy strategies. See Appendix C – Health People 2030 and Appendix D – Health Literacy for details and resources.

c. Community-based partnerships

OMH expects recipients to partner with local community-based organizations including local health departments and community health centers to develop and implement: (1) the health literacy plan, in order to ensure cultural and linguistic appropriateness for racial and ethnic minority populations and other vulnerable populations; and (2) a plan for sustaining adherence to COVID-19 and other future public health recommendations. For the sustained adherence plan, partnerships should: (1) increase the availability, dissemination, adaptation and use of culturally and linguistically appropriate, evidence-based health literacy practices and interventions; and (2) ensure accurate, accessible, acceptable and actionable training, health literacy practices and interventions resources for the identified populations.

d. Quality improvement and evaluation

OMH expects recipients to partner with a Minority Serving Institution (Appendix G) when possible to establish and implement an ongoing quality improvement process and project evaluation. OMH expects recipients to use the quality improvement processes to refine the health literacy interventions that support improvements in the disparities identified in the disparity impact statement. The project evaluation should determine whether the health literacy intervention was implemented as planned, whether it reached the target population described in the Disparity Impact Statement, and whether there were any changes in the access, use and outcomes of COVID-19 vaccination, testing, and related activities (e.g., contact tracing, preventive behaviors). OMH expects recipients to provide periodic project data stratified by demographic characteristics, on changes in the access, use and outcomes of COVID-19 vaccination, testing, and related activities (e.g., contact tracing, preventive behaviors) and project data related to the Healthy People 2030 objectives HC/HIT-01, HC/HIT-02, HC/HIT-03 and IID-D02. See Appendix C – Healthy People 2030 for details and resources.

C. AUTHORITY

42 U.S.C. § 300u-6 (Section 1707 of the Public Health Service Act) and the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260).

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D. FEDERAL AWARD INFORMATION

OMH intends to make funds available for competing grant awards.

We will fund awards for a budget period of up to 2 years with a period of performance of up to 2 years, although we may approve shorter periods of performance. Budget periods may also vary from the estimate indicated below due to timing of award issuance or other administrative factors. Funding is contingent upon the availability of funds, satisfactory progress of the project, adequate stewardship of Federal funds, and the best interests of the Government. Special terms and requirements may be included in any award. See Section H.3.

Award Information

Estimated Federal Funds Available: $ 250,000,000

Anticipated Number of Awards: 73 distributed as follows

Approximately 30 for urban communities

Approximately 43 for rural communities

Award Ceiling (Federal Funds including indirect costs):

$4,000,000 per budget period for urban communities

$3,000,000 per budget period for rural communities

Anticipated Start Date: July 1, 2021

Estimated Period of Performance: Not to exceed 2 years

Anticipated Budget Period Length: 24 months

Type of Award: Grant

Type of Application Accepted: Electronic via Grants.gov ONLY unless an exemption is granted

Classification of the applicant's focus area as either urban or rural communities will be determined based on the Health Resources and Services Administration (HRSA) Office of Rural Health Policy definition of "rural" and the Census Bureau's urban classification where:

- Urban: Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

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- Rural: Rural refers to HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer (https://data.hrsa.gov/tools/rural-health). This webpage allows individuals to search by county or street address and determine rural eligibility.

E. ELIGIBILITY INFORMATION

1. Eligible Applicants

Applicant eligibility is limited to local municipalities. Examples include:

- County or Parish Governments
- City or township governments

The section of the Coronavirus Response and Relief Supplemental Appropriations Act relevant to this program limits awards to States, localities and territories. The appropriation language also allocated separate funding for tribes, tribal organizations, and non-profit urban Indian health organizations. However, individual American Indians/Alaska Natives may be beneficiaries of programs created by recipients under this announcement.

The OASH coordinated a multi-prong approach for distributing COVID-19 relief funds. Under the aforementioned paradigm: funds to states and territories will be distributed through the CDC; funds to tribes, tribal organizations, and non-profit urban Indian health organizations will be distributed through the Indian Health Service (IHS); and funds to local municipalities will be distributed through OMH to reach the most vulnerable populations. Thus, States and U.S. Territories can apply for these separate COVID-19 relief funds announced on Grants.gov. The IHS will make funds available to tribes, tribal organizations, and non-profit urban Indian health organizations using existing methodologies, including distribution through funding mechanisms authorized by the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act.

2. Cost Sharing or Matching

You are not required to provide cost sharing or matching in your proposed budget. If you voluntarily include cost sharing in your application, you must include in your budget narrative a

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non-federal sources justification as described in Section F.3.b.1.t. Voluntary cost sharing is not expected for research applications. During the merit review of an application, cost sharing will only be considered in the overall review of the adequacy of the total proposed budget (Federal and non-Federal share) to support the project proposed. Applications including cost sharing or matching, whether required or voluntary, that result in an award will include the cost sharing or matching commitment on the notice of award at the level proposed in the application. See Section F.3.b.1.s. Any change in the responsibility to provide cost sharing or matching at that level will require prior approval of the grants management officer.

3. Other -- Application Responsiveness Criteria

We will review your application to determine whether it meets the responsiveness criterion below. If your application does not meet the responsiveness criterion, we will disqualify it from the competition; we will not review it beyond the initial screening. The responsiveness criterion is as follows:

- Applicant has identified an urban (as defined by the U.S. Census Bureau) or rural (as defined by HRSA) area of focus in the first sentence of the Project Narrative.

4. Application Disqualification Criteria

If you successfully submit an application, we will screen it to ensure it meets the below requirements. If we determine your application fails to meet the criteria described below we will disqualify it, that is, we will **not** review it and will give it **no** further consideration.

- You must submit your application electronically via www.grants.gov (unless an exemption was granted 2 business days prior to the deadline) by the date and time indicated in the DATES section (A.1) of this announcement.

- If you successfully submit multiple applications from the same organization for the same project, we will only review the last application received by the deadline.

- HHS/OASH/GAM deems your application eligible according to section E.1 Eligible Applicants.
- You must complete the required forms in the application package: SF-424, SF-424A, SF-424B, SF-LLL, and Project Abstract Summary.
- Your Project Narrative section of the application must be double-spaced, on the equivalent of 8 ½ " x 11" inch page size, with 1" margins on all sides (top, bottom, left and right) and font size not less than 12 points.
- Your Project Narrative must not exceed 5 pages. NOTE: The following items do not count toward the Project Narrative page limit: all required forms, including SF-424, SF-424A, SF-424B, SF-LLL, Project Abstract Summary, and Budget Narrative (including budget tables).
- Your total application, including the Project Narrative plus Appendices, must not exceed 15 pages. NOTE: items listed immediately above do not count toward total page limit.
- Your Federal funds request including indirect costs must not exceed the maximum indicated in Award Ceiling.
- Your application must meet the Application Responsiveness Criterion outlined above.

F. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

You may obtain an application package electronically by accessing Grants.gov at http://www.grants.gov/. You can find it by searching on the Assistance Listing (formerly, CFDA) number shown on page 2 of this funding opportunity announcement. If you have problems accessing the application or difficulty downloading, contact:

OASH Grants and Acquisitions Management Division

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Phone: 240-453-8822

Email: OASH_Grants@hhs.gov

2. Content and Form of Application Submission

a. Application Format

Your application must be prepared using the forms and information provided in the online application package.

The Project Narrative, and total application including appendices, must adhere to the page limit indicated in Application Disqualification Criteria listed in Section C. The page limit does not include the Budget Narrative (including budget tables), required forms, assurances, and certifications as described in the Application Disqualification Criteria. Please do not number pages or include a table of contents. Our grants management system will generate page numbers once your application is complete. If your application exceeds the specified page limits for the Project Narrative or Project Narrative plus Appendices when printed on 8.5" X 11" paper by HHS/OASH/GAM, we will not review it. We recommend you print out your application before submitting electronically to ensure that it is within the page limits and is easy to read.

You must double-space the Project Narrative pages.

You should use an easily readable typeface, such as Times New Roman or Arial. You *must* use 12-point font. You may single-space tables or use alternate fonts but you must ensure the tables are easy to read.

b. Appendices Format

Your Appendices should include any specific documents outlined in Section F.3.c, under the heading "Appendices" in the Application Content section of this funding opportunity announcement. Your documents should be easy to read. You should use the same formatting specified for the Project Narrative. However, documents such as résumés/CVs, organizational charts, tables, or letters of commitment may use formatting common to those documents, but the pages must be easy to read. All of your appendices must be uploaded as a single, consolidated file in the Attachments section of your Grants.gov application.

c. Project Abstract Summary Format

You must complete the Project Abstract Summary form provided in the application package. The abstract will be used to provide reviewers with an overview of the application and

will form the basis for the application summary in grants management and program summary documents. If your project is funded, HHS may publish information from your form; therefore, do not include sensitive or proprietary information.

d. Budget Narrative Format

The Budget Narrative should use the formatting required of the Project Narrative for the explanatory text. Budget tables may be single-spaced but should be laid out in an easily-readable format and within the printable margins of the page.

3. Application Content

Successful applications will contain the following information:

a. Project Narrative Content

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether your project meets the minimum requirements for an award under this announcement. The Project Narrative should provide a clear and concise description of your project.

HHS/OASH recommends that your project narrative include the following components: 1) Statement of Need, 2) Proposed Approach, and 3) Organizational Capacity. To facilitate the review of your application we suggest organizing your narrative by these headings.

You must identify an urban (as defined by the U.S. Census Bureau) or rural (as defined by HRSA) area of focus in the first sentence of your Project Narrative.

(1) Statement of Need

Describe the scope of the problem that will be addressed by the proposed project including, the population(s) and geographic area of focus, including the disproportionate impact of COVID-19 on racial and ethnic minority populations in the geographic area of focus.

Provide a table, as an appendix, using quantitative data to describe the target populations at highest risk for experiencing disparities in COVID-19 outcomes. These data should include: (a) racial/ethnic minority populations, (b) COVID-19 positivity rate, (c) households with more persons than rooms, (d) uninsured populations, and (e) populations with Limited English Proficiency consistent with data in the Social Vulnerability Index (https://svi.cdc.gov/prepared-county-maps.html). Alternate data sources can be used, if the SVI data are not available.

(2) Proposed Approach

Describe the project goals, objectives and proposed outcomes. Describe the approach to address the problem described in Section B.2 Expectations. At a minimum, you should:

- Demonstrate how health literacy strategies will be implemented to advance Healthy People 2030 objectives HC/HIT-01, HC/HIT-02 and HC/HIT-03, and improve adherence to COVID-19 public health practices with high-risk and underserved racial and ethnic minority populations in the geographic area of focus.

- Provide a list, as an appendix, that identifies the types of partners and their role in developing and implementing the health literacy and sustainability plans.

- Describe the quality improvement approach that will be used to refine health literacy strategies that support the access, use and outcomes of COVID-19 health information and services for the populations in the geographic area of focus.

- Describe the evaluation approach that will be used to determine whether the health literacy intervention was implemented in adherence with the National CLAS Standards, whether it reached its target population described in the Disparity Impact Statement, and whether there were any changes in access, use and outcomes of program activities, especially COVID-19 testing, contact tracing, vaccination. Include a description of how data stratified by demographic characteristics will be used to advance Healthy People 2030 objectives HC/HIT-01, HC/HIT-02, HC/HIT-03 and IID-D02.

(3) Organizational Capacity

Describe a strategy for minimizing delays in project start-up activities and the roles and responsibilities of project leadership (Principal Investigator and Project Director) in providing project management and oversight.

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Provide a chart, as an appendix, outlining the current and anticipated staffing who will be responsible for implementing for key tasks and monitoring the project's ongoing progress.

Identify the Minority Serving Institution (Appendix G) or other institution/organization that will be responsible for quality improvement and program evaluation and a brief summary of the individual's and institution/organization's qualifications. Describe the degree of independence the evaluator will have. To the extent possible, the applicant should document the level of commitment of any partners as described below in the Appendices (Section F.3.c).

b. Budget Narrative Content

You must complete the required budget forms and submit a budget narrative with detailed justification as part of your application. You must enter the project budget on the Budget Information Non-construction Programs standard form (SF 424A) according to the directions provided with this standard form. The budget narrative consists of a detailed line-item budget that includes calculations for all costs and activities by "object class categories" identified on the SF-424A and justification of the costs. You must indicate the method you are selecting for your indirect cost rate. See Indirect Costs below for further information.

Project budget calculations must include estimation methods, quantities, unit costs, and other similar quantitative detail sufficient to verify the calculations. If matching or cost sharing is required, you must include a detailed listing of any funding sources identified in box 18 of the SF-424 (Application for Federal Assistance).

Please be sure to carefully review section F.7 Funding Restrictions for specific information regarding allowable, unallowable, and restricted costs.

You must provide an object class category budget using Section B, box 6 of the SF 424A for the first year of the proposed project. Provide a budget justification, which includes explanatory text and line-item detail, for the first year of the proposed project. The budget narrative should describe how the categorical costs are derived. Discuss the necessity, reasonableness, and allocation of the proposed costs.

For subsequent budget years, provide a summary narrative and line item budget. For categories or items that differ significantly from the first budget year, provide a detailed justification explaining these changes. Note, **do not** include costs beyond the first budget year in the object class budget in box 6 of the SF- 424A or box 18 of the SF-424; the amounts entered in these sections should only reflect the first budget year.

Your budget narrative should justify the overall cost of the project as well as the proposed cost per activity, service delivered, and/or product. For example, the budget narrative should define the amount of work you have planned and expect to perform, what it will cost, and an explanation of how the result is cost effective. For example, if you are proposing to provide services to clients, you should describe how many clients are you expecting to serve, the unit cost of serving each client, and how this is cost effective.

Use the following guidelines for preparing the detailed object class budget required by box 6 of the SF-424A. The object class budget organizes your proposed costs into a set of defined categories outlined below. Both federal and non-federal resources (when required) must be detailed and justified in the budget narrative. "Federal resources" refers only to the HHS/OASH funds for which you are applying. "Non-federal resources" are all other non-HHS/OASH federal and non-federal resources. We recommend you present budget amounts and computations in a columnar format: first column, object class categories; second column, federal funds requested; third column, non-federal resources; and last column, total budget.

Sample Budget Table

Object Class	Federal Funds Requested	Non-federal Resources	Total Budget
Personnel	$100,000	$25,000	$125,000

Note, subrecipient/contract and consultant detailed costs should all be included in those specific line items, not in the overall project object class line items, e.g., subrecipient travel should be included in the Contractual line item not in Travel.

(1) Object Class Descriptions and Required Justifications

(a) Personnel Description

Costs of staff salaries and wages, excluding benefits.

(b) Personnel Justification

Clearly identify the project director or principal investigator, if known at the time of application. Provide a separate table for personnel costs detailing for each proposed staff person: the title; full name (if known at time of application), time commitment to the project as a percentage or full-time equivalent: annual salary and/or annual wage rate; federally funded award salary; non-federal award salary, if applicable; and total salary. No salary rate may exceed the

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statutory limitation in effect at the time you submit your application (see Section F.7.2) Funding Restrictions, *Salary Rate Limitation* for details). Do not include the costs of consultants, personnel costs of delegate agencies, or of specific project(s) and/or businesses to be financed by the applicant. Contractors and consultants should not be placed under this category.

Sample Personnel Table

Position Title and Full Name	Percent Time	Annual Salary	Federally-funded Salary	Non-federal Salary	Total Project Salary
Project Director, John K. Doe	50%	$100,000	$50,000	$0	$50,000
Data Assistant, Susan R. Smith	10%	$30,000		$3,000	$3,000

(c) Fringe Benefits Description

Costs of employee fringe benefits unless treated as part of an approved indirect cost rate.

(d) Fringe Benefits Justification:

Provide a breakdown of the amounts and percentages that comprise fringe benefit costs such as health insurance, Federal Insurance Contributions Act (FICA) taxes, retirement insurance, and taxes.

(e) Travel Description

Costs of travel by staff of the applicant organization only.

(f) Travel Justification

For each trip proposed for applicant organization staff only, show the date of the proposed travel, total number of traveler(s); travel destination; duration of trip; per diem; mileage allowances, if privately owned vehicles will be used; and other transportation costs and subsistence allowances. **Do not** include travel costs for subrecipients or contractors.

(g) Equipment Description

Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000. (Note: Acquisition cost means the cost of the asset including the cost to ready

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the asset for its intended use. Acquisition cost for equipment, for example, means the net invoice price of the equipment, including the cost of any modifications, attachments, accessories, or auxiliary apparatus necessary to make it usable for the purpose for which it is acquired. Acquisition costs for software includes those development costs capitalized in accordance with generally accepted accounting principles (GAAP). Ancillary charges, such as taxes, duty, protective in transit insurance, freight, and installation may be included in or excluded from the acquisition cost in accordance with the non- Federal entity's regular accounting practices.) See 45 C.F.R. § 75.2 for additional information.

(h) Equipment Justification

For each type of equipment requested you must provide a description of the equipment; the cost per unit; the number of units; the total cost; and a plan for use of the equipment in the project; as well as a plan for the use, and/or disposal of, the equipment after the project ends. An applicant organization that uses its own definition for equipment should provide a copy of its policy, or section of its policy, that includes the equipment definition; include this with your Budget Narrative file. Reference the policy in this justification and include the policy copy in your Budget Narrative file (not your appendices).

(i) Supplies Description

Costs of all tangible personal property other than those included under the Equipment category. This includes office and other consumable supplies with a per-unit cost of less than $5,000.

(j) Supplies Justification

Specify general categories of supplies and their costs. Show computations and provide other information that supports the amount requested.

(k) Contractual Description

Costs of all contracts or subawards for services and goods except for those that belong under other categories such as equipment, supplies, construction, etc. Include third-party evaluation contracts, if applicable, and contracts or subawards with subrecipient organizations (with budget detail), including delegate agencies and specific project(s) and/or businesses to be financed by the applicant. This line item is not for individual consultants.

(l) Contractual Justification

Demonstrate that all procurement transactions will be conducted in a manner to provide, to the maximum extent practical, open, and free competition. Recipients and subrecipients are required to use 45 CFR § 75.329 procedures and must justify any anticipated procurement action that is expected to be awarded without competition and exceeds the simplified acquisition threshold fixed by 41 U.S.C. § 134 and currently set at $250,000. Recipients may be required to make pre-award review and procurement documents, such as requests for proposals or invitations for bids, independent cost estimates, etc., available to HHS/OASH.

Note: Whenever you intend to delegate part of the project to another agency, you must provide a detailed budget and budget narrative for each subrecipient/contractor, by agency title, along with the same supporting information referred to in these instructions. If you plan to select the subrecipients/contractors post-award and a detailed budget is not available at the time of application, you must provide information on the nature of the work to be delegated, the estimated costs, and the process for selecting the delegate agency.

(m)Other Description

Enter the total of all other costs. Such costs, where applicable and appropriate, may include but are not limited to: consultants; insurance; professional services (including audit charges); space and equipment rent; printing and publication; training, such as tuition and stipends; participant support costs including incentives, staff development costs; and any other costs not addressed elsewhere in the budget.

(n) Other Justification

Provide computations, a narrative description, and a justification for each cost under this category.

(o) Indirect Costs Description

Total amount of indirect costs. This category has one of two methods that you may select. You may only select one.

- Your organization currently has an indirect cost rate approved by the Department of Health and Human Services (HHS) or another cognizant federal agency. You should enclose a copy of the current approved rate agreement in your Budget Narrative file. If you request a rate that is less than allowed, your authorized representative must submit a signed

acknowledgement that the organization is accepting a lower rate than allowed.

- Per 45 CFR § 75.414(f) Indirect (F&A) costs, "any non-Federal entity [i.e., applicant] that has never received a negotiated indirect cost rate, … may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in § 75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time."

  This method only applies if you have never received an approved negotiated indirect cost rate from HHS or another cognizant federal agency. If you are waiting for approval of an indirect cost rate, you may request the 10% de minimis rate. If you choose this method, costs included in the indirect cost pool must not be charged as direct costs to the award.

(p) Indirect Costs Justification

Provide the calculation for your indirect costs total, i.e., show each line item included in the base, the total of these lines, and the application of the indirect rate. If you have multiple approved rates, indicate which rate as described in your approved agreement is being applied and why that rate is being used. For example, if you have both on-campus and off-campus rates, identify which is being used and why.

(q) Program Income Description

Program income means gross income earned by your organization that is directly generated by this project if funded except as provided in 45 CFR § 75.307(f). Program income includes but is not limited to income from fees for services performed or the use or rental of real or personal property acquired under the award. Interest earned on advances of Federal funds is not program

income. Except as otherwise provided in Federal statutes, regulations, or the terms and conditions of the Federal award, program income does not include rebates, credits, discounts, and interest earned on any of them. See also 45 CFR §§ 75.307, 75.407 and 35 U.S.C. §§ 200-212 (applies to inventions made under Federal awards).

(r) Program Income Justification

Describe and estimate the sources and amounts of program income that this project may generate if funded. Unless being used for cost sharing, if applicable, these funds should not be added to your budget. This amount should be reflected in box 7 of the SF-424A.

(s) Non-Federal Resources Description

Amounts of non-federal resources that will be used to support the project as identified in box 18 of the SF-424. For all federal awards, any shared costs or matching funds and all contributions, including cash and third-party in-kind contributions, must be accepted as part of the recipient's cost sharing or matching when such contributions meet all of the criteria listed in 45 CFR § 75.306.

For awards that require matching by statute, you will be held accountable for projected commitments of non-federal resources in your application budgets and budget justifications by budget period or by period of performance for fully-funded awards, even if the justification by budget period, or by period of performance for fully-funded awards, exceeds the amount required. Your failure to provide the required matching amount may result in the disallowance of federal funds. If you are funded, you will be required to report these funds on your Federal Financial Reports.

For awards that do not require matching or cost sharing by statute or regulation, where "cost sharing" refers to costs of a project in addition to Federal funds requested that you voluntarily propose in your budget, if your application is successful, we will include this non-federal cost sharing in the approved project budget and you will be held accountable for the non-federal cost-sharing funds as shown in the Notice of Award (NOA). Your failure to provide voluntary cost sharing of non-federal resources that have been accepted by HHS/OASH as part of the approved project costs and that are shown as part of the approved project budget in the NOA may result in the disallowance of federal funds. If you are funded, you will be required to report these funds on your Federal Financial Reports. Note, you will not receive any preference, priority, or special

consideration in the funding process for voluntarily including non-Federal cost sharing in your proposed budget.

(t) Non-federal Resources Justification

You must provide detailed budget information for every funding source identified in box 18. "Estimated Funding ($)" on the SF-424. Provide this documentation as part of your Budget Narrative file, not your Appendices.

You must fully identify and document in your application the specific costs or contributions you propose in order to meet a matching requirement. You must provide documentation in your application on the sources of funding or contribution(s). In-kind contributions must be accompanied by a justification of how the stated valuation was determined. Matching or cost sharing must be documented by budget period (or by period of performance for fully-funded awards). If your application does not include the required supporting documentation for required or voluntary cost-sharing or matching, it will be disqualified from competitive review.

(2) Plan for Oversight of Federal Award Funds

You must include a plan for oversight of federal award funds which describes:

- how your organization will provide oversight of federal funds and how award activities and partner(s) will adhere to applicable federal award and programmatic regulations. Include identification of risks specific to your project as proposed and how your oversight plan addresses these risks.

- the organizational systems that demonstrate effective control over and accountability for federal funds and program income, compare outlays with budget amounts, and provide accounting records supported by source documentation.

- for any program incentives proposed, the specific internal controls that will be used to ensure only qualified participants will receive them and how they will be tracked.

- organizational controls that will ensure timely and accurate submission of Federal Financial Reports to the OASH Grants and Acquisitions Management Division via the Payment Management System as well as

timely and appropriate withdrawal of cash from the Payment Management System.

If your internal controls are available online, you may provide the link as part of your plan in the budget narrative. We have also included in Appendix F which contains questions applicants may find useful in considering their Plan for Oversight of Federal Funds.

c. Appendices

All items described in this section will count toward the total page limit of your application. You must submit them as **a single electronic file** uploaded to the Attachments section of your Grants.gov application.

(1) Project Partners

Include a table that lists partners that have been identified to develop and implement the project. The list of partners should include the partners that provide Letters of Commitment and specific roles, responsibilities, resources, and contributions of each partner.

(2) Documentation of Commitment from Partners, Subrecipient Organizations, and Agencies.

If available at the time of submission, signed MOAs or signed Letters of Commitment (LOCs) may be submitted for each partner (or one signed MOA with all partners) and include specific roles, responsibilities, resources, and contributions of partner(s) to the project. A signed MOA or LOC should be submitted for the Minority Serving Institution that will partner for the quality improvement and program evaluation. If the applicant is unable to submit signed MOAs, the applicant should submit an unsigned MOA(s). Signed MOAs and LOCs must detail the specific role and resources that will be provided, or activities that will be undertaken, in support of the applicant. The organization's expertise, experience, and access to the targeted population(s) should also be described in the MOA or LOC. Fully executed MOAs for all partners, subrecipients, and agencies will be required within 30 days following the issuance of any award made under this announcement.

Letters of commitment are not the same as letters of support. Letters of support are letters that are general in nature that speak to the writer's belief in the capability of an applicant to accomplish a goal/task. Letters of support also may indicate an intent or interest to work together in the future, but they lack specificity. You should NOT provide letters of support, and letters of support such as this will not be considered during the review.

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(3) Organizational Chart

Include an organizational chart that reflects the management structure for the project and demonstrates where the project resides within the greater organization. The chart should include a separate table that outlines the current and anticipated staffing who will be responsible for implementing for key tasks and monitoring the project's ongoing progress.

(4) Summary Bios for Key Project Personnel

You must submit with your application summary resume/biographical sketch not to exceed 2 pages per person for the Project Director/Principal Investigator and all other Key Personnel. You may use a format similar to the NIH biographical sketch (https://grants.nih.gov/grants/forms/biosketch.htm). Key Personnel includes those individuals who will oversee the technical, professional, managerial, and support functions and/or assume responsibility for assuring the validity and quality of your organization's program. This includes at a minimum Program Manager/Program Coordinator. We encourage individuals to use their full name (first, middle, last) on these documents to distinguish them for verification in the System for Award Management exclusion records. Failure to include a full name may delay review of your application.

(5) Project Target Population

You must submit with your application a table outlining the target population to receive services and supports within the identified geographic area of focus using quantitative data. The data should include: (a) racial/ethnic minority populations, (b) COVID-19 positivity rate, (c) households with more persons than rooms, (d) uninsured populations, and (e) populations with Limited English Proficiency consistent with data in the Social Vulnerability Index (https://svi.cdc.gov/prepared-county-maps.html). Alternate data sources can be used, if the SVI data are not available, to describe the target population.

4. Unique Entity Identifier and System for Award Management (SAM)

You are required to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal awards through Grants.gov. It is a unique, nine-digit identification number, which provides unique identifiers of single business entities. The DUNS number is free and easy to obtain. If you do not currently have a DUNS number, please

contact Grants.gov to create a temporary DUNS number if you are unable to complete the SAM registration process prior to submitting your application.

You will find instructions on the Grants.Gov web site as part of the organization registration process at http://www.grants.gov/web/grants/applicants/organization-registration.html.

Your organization must register online in the System for Award Management (SAM). Under normal operating procedures Grants.gov will reject submissions from applicants with nonexistent or expired SAM Registrations. Because of the public health emergency with COVID-19, the requirement for SAM registration at the time of submission has been waived. Grants.gov will temporarily allow submissions without a current SAM registration. A completed registration in SAM may be required prior to receiving any award based on your application.

If you are registering a new entity or renewing your registration, you must submit a notarized letter formally appointing an Entity Administrator to SAM.GOV For detailed instructions on the content of the letter and process for domestic entities see: https://www.fsd.gov/gsafsd_sp?id=gsafsd_kb_articles&sys_id=86ab64e51b9ae050d3ab404fe54bcb6a.

A quick start guide for registrants is available at https://www.sam.gov/SAM/transcript/Quick_Guide_for_Grants_Registrations.pdf. You should allow a minimum of five days to complete an initial SAM registration. Allow up to 10 business days after you submit your registration for it to be active in SAM. This timeframe may be longer if SAM flags the information you provide for manual validation. You will receive an email alerting you when your registration is active.

If your organization is already registered in SAM, you must renew your SAM registration each year. Organizations registered to apply for Federal awards through http://www.grants.gov will need to renew their registration in SAM. SAM has extended the expiration dates for registration renewals that may be delayed because of the public health emergency. Please review your status in SAM.

You should make sure your SAM registration information is accurate, especially your organization's legal name and physical address including your ZIP+4. Should you successfully compete and receive an award, this information must be included on a Notice of Award. For

instructions on updating this information see https://www.sam.gov/SAM/transcript/Quick_Guide_for_Updating_or_Renewing_SAM_Registrations.pdf.

It may take 24 hours or more for SAM updates to take effect in Grants.gov, so if you plan to apply for this funding opportunity or think you might apply, you should ensure your organization's registration is active in SAM well before the application deadline and will be active through the competitive review period.

If you are successful and receive an award, you must maintain an active SAM registration with current information at all times during which your organization has an active award or an application or plan under consideration by an HHS agency.

HHS/OASH cannot make an award until you have complied with these requirements as modified under the public health emergency. If you have not complied with these requirements, HHS/OASH:

- May determine that you are not qualified to receive an award; and
- May use that determination as a basis for making an award to another applicant.

Should you successfully compete and receive an award, all first-tier sub-award recipients must have a DUNS number (permanent or temporary) at the time you, the recipient, make a sub-award.

5. Submission Dates and Times

You must submit your application for this funding opportunity by **the date and time indicated in Section A.1 of this announcement.** Your submission time will be determined by the date and time stamp provided by Grants.gov when you **complete** your submission.

If you fail to submit your application by the due date and time, we will not review it, and it will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or with http://www.grants.gov . Grants.gov can take up to 48 hours to notify you of a successful or rejected submission. You are

better off having a less-than-perfect application successfully submitted and under consideration than no application.

If your submission fails due to a system problem with Grants.gov, we may consider your application if you provide verification from Grants.gov indicating system problems existed at the time of your submission **and that time was before the submission deadline**. A "system problem" does not include known issues for which Grants.gov has posted instructions regarding how to successfully submit an application such as compatible Adobe versions or file naming conventions. **As the applicant, it is your responsibility to review all instructions available on Grants.gov regarding successfully submitting an application.**

6. Intergovernmental Review

Applications under this announcement are subject to the requirements of Executive Order 12372, ''Intergovernmental Review of Federal Programs,'' as implemented by 45 CFR part 100, ''Intergovernmental Review of Department of Health and Human Services Programs and Activities.'' As soon as possible, you should discuss the project with the State Single Point of Contact (SPOC) for the State in which your organization is located. The current listing of the SPOCs is available at https://www.whitehouse.gov/wp-content/uploads/2020/04/SPOC-4-13-20.pdf.

The SPOC should forward any comments to the Department of Health and Human Services 1101 Wootton Parkway, Plaza Level, Rockville, MD 20852. The SPOC has 60 days from the due date listed in this announcement to submit any comments. For further information, contact the HHS/OASH Grants and Acquisitions Management Division at 240–453–8822 or OASH_Grants@hhs.gov.

7. Funding Restrictions

Direct and Indirect Costs proposed and, if successful, charged to the HHS/OASH award must meet the cost requirements of 45 CFR part 75 "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards," Subpart E—Cost Principles. These requirements apply to you, the applicant, and any subrecipients. You should thoroughly review these regulations before developing your proposed budget.

Indirect costs may be included per 45 CFR § 75.414. See the Budget Narrative section of this announcement for more information. To obtain a negotiated indirect cost rate with the Federal Government you may contact the U.S. Department of Health and Human Services Cost Allocation Services (CAS) regional office that is applicable to your State. CAS regional contact information is available at https://rates.psc.gov/fms/dca/map1.html.

a. Pre-Award Costs

Pre-award costs (per 45 CFR § 75.458) are those incurred prior to the effective date of the Federal award directly pursuant to the negotiation and in anticipation of the Federal award where such costs are necessary for efficient and timely performance of the scope of work. Such costs are allowable only to the extent that they would have been allowable if incurred after the date of the Federal award and only with the written approval of the HHS awarding agency.

Pre-award costs are NOT allowed.

b. Salary Rate Limitation:

Each year's appropriations act limits the salary rate that we may award and you may charge to HHS/OASH grants and cooperative agreements. You should not budget award funds to pay the salary of an individual at a rate in excess of Federal Executive Pay Scale Executive Level II. As of January 2021, the Executive Level II salary is $199,300. This amount reflects an individual's base salary exclusive of fringe benefits and any income that an individual working on the award project may be permitted to earn outside of the duties to the applicant organization. This salary rate limitation also applies to subawards/subcontracts under an HHS/OASH award.

An example of the application of this limitation for an individual devoting 50% of their time to this award is broken down below:

Individual's *actual* base full time salary: $350,000 50% of time devoted to project, i.e., 0.5 FTE	
Direct salary ($350,000 x 0.5)	$175,000
Fringe (25% of salary)	$43,750
Total	$218,750

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Amount that may be claimed on the application budget due to the legislative salary rate limitation: Individual's base full time salary *adjusted* to Executive Level II: $199,300 with 50% of time devoted to the project	
Direct salary ($199,300 x 0.5)	$99,650
Fringe (25% of salary)	$24,913
Total amount allowed	$124,563

Appropriate salary rate limits will apply as required by law.

8. Other Submission Requirements

a. Electronic Submission

HHS/OASH requires that all applications be submitted electronically via the Grants.gov portal unless an exemption has been granted. If you submit an application via any other means of electronic communication, including facsimile or electronic mail, it *will not* be accepted for review unless you receive an exemption as described in the DATES section of this announcement.

You may access the Grants.gov website portal at http://www.grants.gov.

Applications, excluding required standard forms, must be submitted as three (3) files (see acceptable file types below). One file must contain the entire Project Narrative, another the entire Budget Narrative including supporting documentation described in the Budget Narrative content section; and the third file must contain all documents in the Appendices. Any additional files submitted as part of the Grants.gov application will not be accepted for processing and will be excluded from the application during the review process.

Any files uploaded or attached to the Grants.gov application must be Adobe PDF, Microsoft Word, or image formats (JPG, GIF, TIFF, or BMP only) and must contain a valid file format extension in the filename. HHS/OASH strongly recommends that electronic applications be uploaded as Adobe PDF. If you convert to PDF prior to submission you may prevent any unintentional formatting that might occur with submission of an editable document. Please note, even though Grants.gov allows you to attach any file format as part of your application,

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HHS/OASH restricts this practice and only accepts the file formats identified above. Any file submitted as part of the Grants.gov application that is not in a file format listed above will not be accepted for processing and will be excluded from the application during the review process.

Any file submitted as part of the Grants.gov application that contains password protection will not be accepted for processing and will be excluded from the application during the review process. We will not contact you for passwords or resubmission of unprotected files. Unprotected information in the application will be forwarded for consideration but password protected portions will not. You should avoid submitting personally identifiable information such as personal contact information on résumés.

In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. We will not contact you for resubmission of uncompressed versions of files. Compressed information in the application will not be forwarded for consideration.

You must submit your application in a format that can easily be copied and read by reviewers. We do not recommend that you submit scanned copies through Grants.gov unless you confirm the clarity of the documents. Pages cannot be reduced resulting in multiple pages on a single sheet to avoid exceeding the page limitation. If you submit documents that do not conform to these instructions, we will exclude them from your application during the review process.

b. Important Grants.gov Information

You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number or Assistance Listing (formerly, CFDA) number, both of which can be found on page 1 of this funding opportunity announcement.

To ensure successful submission of your application, you should carefully follow the step-by-step instructions provided at http://www.grants.gov/web/grants/applicants/apply-for-grants.html . These instructions are kept up-to-date and also provide links to Frequently Asked Questions and other troubleshooting information. **You are responsible for reviewing all Grants.gov submission requirements on the Grants.gov site.**

You should contact Grants.gov with any questions or concerns regarding the electronic application process conducted through Grants.gov. See Contacts below. See Section F.4 for requirements related to DUNS numbers and SAM registration.

G. APPLICATION REVIEW INFORMATION

1. Criteria

Federal staff and an independent review panel will assess all eligible applications according to the following three equally-weighted criteria: 1) statement of need, 2) proposed approach, and 3) organizational capacity. Disqualified applications will not be reviewed against these criteria

a. Statement of Need

- How well does the applicant describe the problem and contributing factors of the problem to demonstrate need for the project?
- How well is the population(s) and geographic area of focus described using data on demographic characteristics (e.g., race/ethnicity, rural/urban, limited English proficiency) and characteristics associated with social vulnerability and individuals at highest risk for experiencing disparities in COVID-19 outcomes (e.g., COVID-19 positivity per capita rate, CDC SVI index rating)?
- How well does the applicant demonstrate understanding of disproportionate impact of COVID-19 on high-risk and underserved racial and ethnic minority populations in the geographic area of focus?
- How well does the applicant describe the approach for developing a disparity impact statement?

b. Proposed Approach

- How well does the applicant describe and discuss project details, including the project goals, objectives, and proposed outcomes?
- How feasible, data-driven and culturally and linguistically appropriate is the proposed approach for applying health literacy strategies to improve the access, use and outcomes of COVID-19 health information and services for the population of focus?

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- How well does the applicant describe the approach for implementing health literacy strategies to address the Health People objectives HC/HIT-01, HC/HIT-02 and HC/HIT-03?

- To what extent are the proposed outcome(s) feasible, measurable and unambiguously aligned with the program goals and objectives?

- How well does the applicant describe partnerships with community-based organizations to support the development and implementation of the health literacy plan and sustainability plan?

- How well does the applicant describe an adequate quality improvement approach to refine interventions and support improved health literacy related to the access, use and outcomes of COVID-19 health information and services for the populations in the geographic area of focus?

- How adequate and feasible is the evaluation approach for determining whether the health literacy intervention was implemented in adherence with the National CLAS Standards, whether it reached its target population described in the Disparity Impact Statement, and whether there were any changes in access, use and outcomes of COVID-19 vaccination, testing, and related activities (e.g., contact tracing, preventive behaviors)? How adequately does the applicant describe the use of data, stratified by demographic characteristics, to advance Healthy People 2030 objectives HC/HIT-01, HC/HIT-02, HC/HIT-03 and IID-D02?

c. Organizational Capacity

- How well does the applicant demonstrate a strategy for minimizing start-up delays?

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- How adequate are the roles and responsibilities of project leadership in providing project management and oversight? How well does the organizational chart demonstrate adequate project staffing?

- How well does the applicant describe the partnership with an institution/organization for quality improvement and program evaluation?

2. Review and Selection Process

Each HHS/OASH Program's office is responsible for facilitating the process of evaluating applications and setting funding levels according to the criteria set forth above.

An independent review panel will evaluate applications that meet the responsiveness criteria, if applicable, and are not disqualified. These reviewers are experts in their fields, and are drawn from academic institutions, non-profit organizations, state and local government, and Federal government agencies. Based on the Application Review Criteria as outlined under Section E.1, the reviewers will comment on and evaluate the applications, focusing their comments and reviews on the identified criteria. In addition to the independent review panel, Federal staff will review each application for programmatic, budgetary, and grants management compliance.

The Deputy Assistant Secretary for Minority Health will provide recommendations for funding to the Grants Management Officer to conduct risk analysis.

In providing these recommendations, the Deputy Assistant Secretary for Minority Health will take into consideration the following additional factor(s) in no particular order:

- Applicants serving localities with the highest social vulnerability. This may be determined by being in the top 4th as defined by the CDC's Social Vulnerability Index (SVI) county maps at https://svi.cdc.gov/prepared-county-maps.html, or alternate similar data source if SVI is not available.

- Applicants with identified Minority Serving Institution partners. Minority Serving Institutions are defined by the U.S. Department of Education as a category of institutions of higher education enrolling

populations with significant percentages of undergraduate minority students, or that serve certain populations of minority students under various programs created by Congress. Find the full definition and list of Minority Serving Institutions here: https://www2.ed.gov/about/offices/list/ocr/edlite-minorityinst.html.
See Appendix G for a list of Minority Serving Institutions, which can also be found here https://www.minorityhealth.hhs.gov/assets/PDF/2020_Minority_Serving_Institutions.pdf.

Find additional information on Minority Serving Institutions here: https://www2.ed.gov/about/offices/list/ocr/edlite-minorityinst.html.

- Equitable geographic distribution.

3. Review of Risk Posed by Applicant

The HHS/OASH will evaluate, in accordance with 45 CFR § 75.205, each application recommended for funding by the program official indicated in Review and Selection Process for risks before issuing an award. This evaluation may incorporate results of the evaluation of eligibility or the quality of an application. If we determine that a Federal award will be made, special conditions that correspond to the degree of risk assessed will be applied to the Federal award. Such conditions may include additional programmatic or financial reporting or releasing funds on a reimbursable rather than cash advance basis. OASH will use a risk-based approach and may consider any items such as the following:

a. Your financial stability;
b. Quality of management systems and ability to meet the management standards prescribed in 45 CFR part 75;
c. History of performance. Your record in managing Federal awards, if you are a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of

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previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

d. Reports and findings from audits performed; and
e. Your ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

Prior to making a Federal award with a total Federal share greater than the simplified acquisition threshold (currently $250,000), we are required to review and consider any information about you that is in the designated integrity and performance system accessible through the System for Award Management (SAM) (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)).You may, at your option, review information in SAM and comment on any information about yourself that a Federal awarding agency previously entered and is currently available through SAM. We will consider any comments by you, in addition to the other information in the designated system, in making a judgment about your integrity, business ethics, and record of performance under Federal awards when completing the review of risk.

If we do not make an award to you because we determine your organization does not meet either or both of the minimum qualification standards as described in 45 CFR §75.205(a)(2), we must report that determination to FAPIIS, if certain conditions apply. At a minimum, the information in the system if you are a prior Federal award recipient must "demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics." 45 CFR § 75.205(a)(2); see also 45 CFR §75.212 for additional information.

4. Final Award Decisions, Anticipated Announcement, and Federal Award Dates

Upon completion of risk analysis and concurrence of the Grants Management Officer, HHS/OASH will issue Notices of Award. No award decision is final until a Notice of Award is issued. All award decisions, including level of funding if an award is made, are final and you may not appeal.

HHS/OASH seeks to award funds as much in advance of the anticipated project start date shown in Section B "Federal Award Information," as practicable. Note this is an estimated start

date and award announcements may be made at a later date and with a later period of performance start date.

H. FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

HHS/ OASH does not release information about individual applications during the review process. If you would like to track your application, please see instructions at http://www.grants.gov/web/grants/applicants/track-my-application.html. The official document notifying you that an application has been approved for funding is the Notice of Award (NOA), approved by a Grants Management Officer of the HHS/OASH GAM. If you are successful, you will receive this document via system notification from our grants management system (Grant Solutions) and/or via e-mail. This document notifies the successful recipient of the amount awarded, the purposes of the award, the anticipated length of the period of performance, terms and conditions of the award, and the amount of funding to be contributed by the recipient to project costs, if applicable.

If you receive an NOA, we strongly encourage you to read the entire document to ensure your organization's information is correct and that you understand all terms and conditions. You should pay specific attention to the terms and conditions, as some may require a time-limited response. The NOA will also identify the Grants Management Specialist and Program Project Officer assigned to the award for assistance and monitoring.

If you are unsuccessful or deemed ineligible according to the disqualification criteria, you will be notified by HHS/OASH by email and/or letter. If your application was reviewed by the independent review panel, you may receive summary comments pertaining to the application resulting from the review process. On occasion, you may receive a letter indicating that an application was approved but unfunded. These applications may be kept active for one year and may be considered for award without re-competing should funds become available during the hold period.

2. Administrative and National Policy Requirements

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently

in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisionsIn addition, your organization must comply with all terms and conditions outlined in the Notice of Award, the U.S. Department of Health and Human Services (HHS) Grants Policy Statement (GPS), requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable, as well as any requirements or limitations in any applicable appropriations acts. The current HHS GPS is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf. Please note HHS plans to revise the HHS GPS to reflect changes to the regulations; 45 CFR parts 74 and 92 have been superseded by 45 CFR part 75.

You may only use award funds to support activities outlined in the approved project plan. If your application is funded, your organization will be responsible for the overall management of activities within the scope of the approved project plan. Please consult the HHS GPS Section II and 45 CFR § 75.308 for aspects of your funded project that will require prior approval from the Grants Management Officer for any changes. Modifications to your approved project that will require prior approval include, but are not limited to: a change in the scope or the objective(s) of the project or program (even if there is no associated budget revision, such as reduction in services, closing of service or program site(s)); significant budget revisions, including changes in the approved cost-sharing or matching; a change in a key person specified in your application; reduction in time devoted to the project by the approved project director or principal investigator, either as percentage of full-time equivalent of 25% or more or absence for 3 months or more; or the subawarding, transferring or contracting out of any work that was not described in the approved proposal.

3. Program Specific Terms and Conditions

Notices of award may include one or more of the following special conditions:

a. If not registered at time of award, submission of documentation of a valid SAM registration within 30 days of the beginning of the period of performance.

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b. Submission of all Institutional Review Board approvals prior to the start of any work requiring approval. (Section H.14)
c. Incremental spending rates (for example, 25% of the total federal budget awarded each 6 months) that can be modified with prior written approval by the grants management officer.
d. Other reporting as may be required by statute for the funding awarded under this announcement.
e. Submission of more detailed planning documents consistent with the project and budget narratives submitted in your application, including but not limited to:
   (1) Confidentiality Plan
   (2) Work Plan
   (3) Disparity Impact Statement
   (4) Health Literacy Plan that incorporates the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
   (5) Evaluation Plan

4. Closeout of Award

Upon expiration of your period of performance, if we do not receive acceptable final performance, financial, and/or cash reports in a timely fashion within the closeout period, and we determine that closeout cannot be completed with your cooperation or that of the Principal Investigator/ Project Director, we will complete a unilateral closeout. (See H.14 Reporting below for closeout reporting requirements). As a result, we will be required to report your material failure to comply with the terms and conditions of the award with the OMB-designated integrity and performance system (currently FAPIIS). We may also determine that enforcement actions are necessary, including on another existing or future award, such as withholding support or a high-risk designation.

5. Lobbying Prohibitions

You shall not use any funds from an award made under this announcement for other than normal and recognized executive legislative relationships. You shall not use funds for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

You shall not use any funds from an award made under this announcement to pay the salary or expenses of any employee or subrecipient, or agent acting for you, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State or local government in policymaking and administrative processes within the executive branch of that government.

The above prohibitions include any activity to advocate or promote any proposed, pending, or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

6. Non-Discrimination Requirements

Pursuant to Federal civil rights laws, if you receive an award under this announcement you must not discriminate on the basis of race, color, national origin, disability, age, and in some cases sex and religion. The HHS Office for Civil Rights provides guidance for complying with civil rights laws that prohibit discrimination. See https://www.hhs.gov/civil-rights/index.html.

HHS provides guidance to recipients of federal financial assistance on meeting the legal obligation to take reasonable steps to provide meaningful access to persons with limited English proficiency. See *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*,

68 Fed. Reg. 47311, 47313 (HHS Office for Civil Rights, 2003, www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf) You must ensure your contractors and subrecipients also comply with federal civil rights laws.

The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (National CLAS Standards), 78 Fed. Reg. 58539, 58543 (HHS Office of Minority Health, 2013, www.gpo.gov/fdsys/pkg/FR-2013-09-24/pdf/2013-23164.pdf), provides a practical framework for applicants to provide quality health care and services to culturally and linguistically diverse communities, including persons with limited English proficiency. Compliance with the National CLAS Standards meets the legal obligation to take reasonable steps to provide meaningful access to persons with limited English proficiency.

7. Smoke- and Tobacco-free Workplace

The HHS/OASH strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. This is consistent with the HHS/OASH mission to protect and advance the physical and mental health of the American people.

8. Acknowledgement of Funding

Each year's annual appropriation requires that when issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all organizations receiving Federal funds, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state— (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

You must also acknowledge Federal support in any publication you develop using funds awarded under this program, with language such as:

> This [project/publication/program/website, etc.] was supported by [Award Number] issued by the Office of the Assistant Secretary for Health of the U.S.

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Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with 100 percent funded by the Office of Minority Health/OASH/HHS.

Recipients must also include a disclaimer stating the following

The contents are solely the responsibility of the author(s) and do not necessarily represent the official views of, nor an endorsement by the Office of Minority Health/OASH/HHS, or the U.S. Government. For more information, please visit https://minorityhealth.hhs.gov.

9. HHS Rights to Materials and Data

All publications you develop or purchase with funds awarded under this announcement must be consistent with the requirements of the program. You own the copyright for materials that you develop under this award, and pursuant to 45 CFR § 75.322(b), HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for Federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal government has the right to obtain, reproduce, publish, or otherwise use data produced under this award and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

10. Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. § 7104) (https://www.govinfo.gov/content/pkg/USCODE-2010-title22/html/USCODE-2010-title22-chap78-sec7104.htm).

11. Efficient Spending

This award may also be subject to the HHS Policy on Promoting Efficient Spending: Use of Appropriated Funds for Conferences and Meetings, Food, Promotional Items, and Printing and Publications available at http://www.hhs.gov/grants/contracts/contract-policies-regulations/efficient-spending/

12. Whistleblower Protection

If you receive an award, you will be subject to a term and condition that applies the terms of 48 CFR § 3.908 to the award, and requires that you inform your employees in writing of employee whistleblower rights and protections under 41 U.S.C. § 4712 in the predominant native language of the workforce.

13. Prohibition on certain telecommunications and video surveillance services or equipment.

As described in 2 CFR 200.216, recipients and subrecipients are prohibited from obligating or spending grant funds (to include direct and indirect expenditures as well as cost share and program) to:

a. Procure or obtain;

b. Extend or renew a contract to procure or obtain; or

c. Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Pub. L. 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(1) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

(2) Telecommunications or video surveillance services provided by such entities or using such equipment.

(3) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director

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of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise, connected to the government of a covered foreign country.

14. Human Subjects Protection

Federal regulations (45 CFR Part 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, you must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in 45 CFR part 46. You may find it online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

Applicants that plan to engage in research involving human subjects are encouraged to provide information regarding participation in research in their recruitment efforts and provide a link to www.hhs.gov/about-research-participation.

OASH may require, as part of any award, the submission of all IRB approvals within 5 days of the IRB granting the approval and before any work requiring IRB approval begins.

15. Research Integrity

An applicant for or recipient of PHS support for biomedical or behavioral research, research training or activities related to that research or research training must comply with 42 C.F.R. part 93, including have written policies and procedures for addressing allegations of research misconduct that meet the requirements of part 93, file an Assurance of Compliance with the Office of Research Integrity (ORI), and take all reasonable and practical steps to foster research integrity consistent with 42 C.F.R. § 93.300. The assurance must state that the recipient (1) has written policies and procedures in compliance with this part for inquiring into and investigating allegations of research misconduct; and (2) complies with its own policies and procedures and the requirements of part 93. More information is available at ori.hhs.gov/assurance-program.

16. Reporting

a. Performance Reports

You must submit performance reports on a quarterly basis, subject to any special conditions that may apply to your award. Your performance reports must address content required by 45 CFR § 75.342(b)(2). The awarding program office may provide additional guidance on the content of the progress report. You must submit your performance reports by the due date indicated in the terms and conditions of your award via upload to our grants management system (GrantSolutions.gov), in the Grant Notes module.

You will also be required to submit a final performance report covering the entire period of performance 90 days after the end of the period of performance. You must submit the final report by upload to our grants management system (GrantSolutions.gov), in the Grant Notes module.

b. Performance Measures

In addition to the submission of quarterly reports in our grants management system, OMH expects awardees to report program process and outcome data electronically to OMH on a quarterly basis. Performance process and outcome data allow OMH to evaluate the performance of its initiatives across awardees. All OMH awardees under this initiative are required to report project performance process and outcome data on a quarterly basis through Grant Solutions. No performance measure reporting will be required without OMB approval. Training will be provided to all new grantees on the collection and reporting of performance data during the Technical Assistance and Training grantee meeting.

At the end of each quarter of this initiative, you should be able to report on the following:

(1) the specific evidence-based health literacy intervention(s) implemented
(2) the number of individuals impacted by the health literacy intervention
(3) the demographic characteristics of the populations reached through the evidence-based health literacy intervention and how the populations reached align with the target population in the Disparity Impact Statement
(4) current project data, stratified by demographic characteristics, on changes in the access, use and outcomes of COVID-19 vaccination, testing, and related activities (e.g., contact tracing, preventive behaviors),

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(5) current project data related to Healthy People 2030 objectives HC/HIT-01, HC/HIT-02, HC/HIT-03 and IID-D02

Note: Recipients also may be required to report project-related data in the Office of Minority Health's Performance Data System (PDS) (OMB No. 0990-0275, Expiration date 8/31/2022).

c. Financial Reports

You will be required to submit quarterly Federal Financial Reports (FFR) (SF-425). Your specific reporting schedule will be issued as a condition of award. You will also be required to submit a final FFR covering the entire period of performance 90 days after the end of the period of performance. You must submit FFRs via our grants management system (GrantSolutions.gov) FFR module.

Quarterly cash reporting to the HHS Payment Management System on the FFR is also required. Please note, at this time, these FFR reports are separate submissions via the Payment Management System. At this time, data is not transferable between the two systems and you will report twice on certain data elements.

d. Audits

If your organization receives $750,000 or greater in Federal funds, it must undergo an independent audit in accordance with 45 CFR part 75, subpart F.

e. FFATA and FSRS Reporting

The Federal Financial Accountability and Transparency Act (FFATA) requires data entry at the FFATA Subaward Reporting System (http://www.FSRS.gov) for all sub-awards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both recipient and sub-award organizations.

f. Reporting of Matters Relating to Recipient Integrity and Performance

If the total value of your currently active grants, cooperative agreements, and procurement contracts from all Federal awarding agencies exceeds $10,000,000 for any period of time during the period of performance of this Federal award, then you must maintain the currency of information reported to the System for Award Management (SAM) that is made available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)) about civil, criminal, or administrative proceedings

described in paragraph A.2 of Appendix XII to 45 CFR part 75—Award Term and Condition for Recipient Integrity and Performance Matters. This is a statutory requirement (41 U.S.C. § 2313). As required by section 3010 of Public Law 111-212, all information posted in the designated integrity and performance system on or after April 15, 2011, except past performance reviews required for Federal procurement contracts, will be publicly available. For more information about this reporting requirement related to recipient integrity and performance matters, see Appendix XII to 45 CFR part 75.

g. Other Required Notifications

Before you enter into a covered transaction at the primary tier, in accordance with 2 CFR § 180.335, you as the participant must notify HHS/OASH, if you know that you or any of the principals for that covered transaction:

- Are presently excluded or disqualified;
- Have been convicted within the preceding three years of any of the offenses listed in 2 CFR § 180.800(a) or had a civil judgment rendered against you for one of those offenses within that time period;
- Are presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses listed in 2 CFR § 180.800(a); or
- Have had one or more public transactions (Federal, State, or local) terminated within the preceding three years for cause or default.

At any time after you enter into a covered transaction, in accordance with 2 CFR § 180.350, you must give immediate written notice to HHS/OASH if you learn either that—

- You failed to disclose information earlier, as required by 2 CFR § 180.335; or
- Due to changed circumstances, you or any of the principals for the transaction now meet any of the criteria in 2 CFR § 180.335.

I. CONTACTS

1. Administrative and Budgetary Requirements

For information related to administrative and budgetary requirements, contact the HHS/OASH grants management specialist listed below.

Roscoe Brunson, Jr.

Senior Grants Management Specialist

Grants and Acquisitions Management

1101 Wootton Parkway, Plaza Level

Rockville, MD 20852

Phone: 240-453-8822

Email: Roscoe.Brunson@hhs.gov

2. Program Requirements

For information on program requirements, please contact the program office representative listed below.

Paul Rodriguez

1101 Wootton Parkway

Rockville, MD 20852

Phone: 240-453-8208

Email: Paul.Rodriguez@hhs.gov

3. Electronic Submission Requirements

For information or assistance on submitting your application electronically via Grants.gov, please contact Grants.gov directly. Assistance is available 24 hours a day, 7 days per week.

GRANTS.GOV Applicant Support

Website: www.grants.gov

Phone: 1-800-518-4726

Email: support@grants.gov

J. OTHER INFORMATION

1. Awards under this Announcement

We are not obligated to make any Federal award as a result of this announcement. If awards are made, they may be issued for periods shorter than indicated. Only the grants officer can bind the Federal government to the expenditure of funds. If you receive communications to negotiate an award or request additional or clarifying information, this does not mean you will receive an award; it only means that your application is still under consideration.

2. Application Elements

The below is a summary listing of all the application elements required for this funding opportunity.

- Application for Federal Assistance (SF-424)
- Budget Information for Non-construction Programs (SF-424A)
- Assurances for Non-construction Programs (SF-424B)
- Disclosure of Lobbying Activities (SF-LLL)
- Project Abstract Summary
- Project Narrative – Submit all Project Narrative content as a single acceptable file, specified above.
- Budget Narrative – Submit all Budget Narrative content as a single acceptable file, specified above.
- Appendices – Submit all appendix content as a single acceptable file, specified above **in the Attachments section of your Grants.gov application**.
    - Project Partners Table
    - Documentation of Commitment from Partners, Subrecipient Organizations, and Agencies

- Organizational Chart
- Summary Bios for Key Project Personnel
- Project target population

_____ _____

Roslyn Holliday Moore Date
Acting Director, Office of Minority Health

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APPENDICES

A. References

1. U.S. Department of Health and Human Services. HHS Strategic Plan 2018-2022. Accessed from: https://www.hhs.gov/about/strategic-plan/index.html

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3. Centers for Disease Control and Prevention. COVID-19 Hospitalization and Death by Race/Ethnicity. Accessed from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

4. Paasche-Orlow MK, Wolf MS. The causal pathways linking health literacy to health outcomes. Am J Health Behav. 2007 Sep-Oct;31 Suppl 1:S19-26. doi: 10.5555/ajhb.2007.31.supp.S19. PMID: 17931132.

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6. Disparities in Adherence to COVID-19 Public Health Recommendations https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7410493/

7. U.S. Department of Health and Human Services. Disparities. Accessed from: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

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8. U.S. Department of Health and Human Services. Healthy People 2030. Accessed from: https://health.gov/healthypeople

9. U.S. Department of Education. Lists of Postsecondary Institutions Enrolling Populations with Significant Percentages of Undergraduate Minority Students. Accessed from: https://www2.ed.gov/about/offices/list/ocr/edlite-minorityinst.html

10. United States Census Bureau. Urban and Rural. Accessed from: https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html

11. Centers for Disease Control and Prevention Social Vulnerability Index Accessed from: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

12. Flanagan, B.E.; Gregory, E.W.; Hallisey, E.J.; Heitgerd, J.L.; and Lewis, B. (2011). "A Social Vulnerability Index for Disaster Management," Journal of Homeland Security and Emergency Management: Vol. 8: Iss. 1, Article 3. DOI: 10.2202/1547-7355.1792

13. Bergstrand, K., Mayer, B., Brumback, B., & Zhang, Y. (2015). Assessing the Relationship Between Social Vulnerability and Community Resilience to Hazards. Social indicators research, 122(2), 391–409. https://doi.org/10.1007/s11205-014-0698-3

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B. Glossary

Disparity impact statement refers to the demographic cultural, and linguistic data that identify the population(s) in which health disparities exist and the quality improvement plan designed to address the noted disparities.

Health disparity refers to a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (7)

Health equity refers to the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."(7)

Health literacy addresses both personal health literacy and organizational health literacy and provides the following definitions:

- **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

- **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. (8)

Minority Serving Institution includes any of the following (as defined in the Higher Education Act) (9):

a part B institution (a historically Black college or university) (§322 of the HEA, 20 U.S.C. §1061);

a Hispanic-serving institution (§502 of the HEA, 20 U.S.C. §1101a);

a Tribal College or University (§316 of the HEA, 20 U.S.C. §1059c);

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an Alaska Native-serving institution or a Native Hawaiian-serving institution (§317(b) of the HEA, 20 U.S.C. §1059d(b);

a Predominantly Black Institution (§§318(b) and 371(c)(9) of the HEA; 20 U.S.C. §§ 1059e(b) and 1067q(c)(9));

an Asian American and Native American Pacific Islander-serving institution (§§ 320(b) and 371(c)(2) of the HEA, 20 U.S.C. §§1059g(b) and 1067q(c)(2). ; or

a Native American-serving nontribal institution (§§319(b) and 371(c)(8) of the HEA; 20 U.S.C. §§ 1059f(b) and 1067q(c)(8).

Find additional information on Minority Serving Institutions here: https://www2.ed.gov/about/offices/list/ocr/edlite-minorityinst.html.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care provide guidance for providing health care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Additional information can be found here: https://thinkculturalhealth.hhs.gov/clas.

Rural communities refers to Health Resources and Services Administration-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer (https://data.hrsa.gov/tools/rural-health). This webpage allows individuals to search by county or street address and determine rural eligibility.

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Socially vulnerable groups refers to individuals, communities or populations that have characteristics that affect their capacity to anticipate, confront, repair, and recover from the effects of a disaster (11). Such characteristics include (11, 12, 13):

- Individual and household traits such as low socioeconomic status, being a racial or ethnic minority, having limited English proficiency, being a child or elderly, being unemployed, lacking access to a vehicle or being dependent on public transportation, having low educational attainment, living in overcrowded conditions, or being homeless

- Systemic and structural factors such as residing in areas that are densely populated, lack healthcare facilities and resources, are rural or urban, or have weak economies

Urban communities refers to U.S. Census Bureau delineated urban areas, which represent densely developed territory, and encompass residential, commercial, and other non-residential urban land use (10). The Census Bureau identifies two types of urban areas:

- Urbanized Areas (UAs) of 50,000 or more people;
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

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C. Healthy People 2030: Health Literacy Definitions and Objectives

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade (8). Healthy People 2030 recognizes that achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.

Health Literacy Definition and Impact on Health

Healthy People 2030 has elevated the importance of health literacy by declaring it a foundational principle and overarching goal, and by adopting two definitions that together constitute health literacy.

- Personal Health Literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and their others.

- Organizational Health Literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and their others.

There are six Healthy People 2030 Health Literacy Objectives:

- HC/HIT-01: Increase the proportion of adults whose health care provider checked their understanding

- HC/HIT-02: Decrease the proportion of adults who report poor communication with their health care provider

- HC/HIT-03: Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted

- HC/HIT-D10; Increase the proportion of people who say their online medical record is easy to understand

- HC/HIT-D11Increase the proportion of adults with limited English proficiency who say their providers explain things clearly

- HC/HIT-R01: Increase the health literacy of the population

A selected Healthy People 2030 Immunization and Infectious Diseases Objective is also noted below:

- IID-D02: Increase the proportion of people with vaccination records in an information system

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D. Health Literacy Resources

As a national priority, health literacy is a recognized support for increasing participation in health care, improving health outcomes and addressing health disparities. Health literacy requires a complex group of reading, listening, analytical, and decision-making skills, as well as the ability to apply these skills to health situations.

Individuals with limited health literacy have reported poorer health status and were less likely to use preventative care. (14) Beyond differences of language, culture gives significance to health information and messages. Perceptions and definitions of health and illness, preferences, language and cultural barriers, care process barriers, and stereotypes are all strongly influenced by culture and can have a great impact. (14)

The U.S. Department of Health and Human Services offers a number of resources and tools to support understanding and implementation of health literacy strategies, including the following:

Health Literacy Plans

- Health Literacy Universal Precautions Toolkit, 2nd Edition -. Agency for Healthcare Research and Quality (AHRQ) toolkit to help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels.

- Create a Health Literacy Plan - resources to support organizations in developing a health literacy plan.

- Health Literate Care Model - tool that incorporates health literacy principles to mitigate risks of individuals not understanding health information.

Quality Improvement and Program Evaluation

- Framework for Program Evaluation - a description of the CDC's Framework for Program Evaluation and possible sources of communication and health literacy measures.

- Healthy People 2030 Health Literacy Objectives - related to health communication and information technology.

Interventions to Improve Health Literacy

- National Action Plan to Improve Health Literacy - overarching guidance based on the principles that (1) everyone has the right to health information that helps them make informed decisions and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life.

- AHRQ Teach-Back Intervention – AHRQ webpage for Teach-Back Intervention, a technique for health care providers to ensure that they have explained medical information clearly so that patients and their families understand what is communicated to them. Includes materials to support adoption.

- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care - guidance for providing health care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Additional Resources and Tools

- Health Literacy Online - information to develop effective products for all users, including those with limited literacy or health literacy.

- Assess Health Literacy in Your Organization - General assessments tools to identify opportunities and barriers for planning purposes and making progress on health literacy.

- CDC Culture and Health Literacy Webpage – Webpage with overview of culture and communication, and tools for organizations to support cross-cultural communication and language access.

- HRSA Health Literacy Webpage - Health Resources and Services Administration (HRSA) health literacy webpage with overview of patient health literacy and strategies for health care professionals.

- AHRQ Patient Education Materials Assessment Tool (PEMAT) and User's Guide - An instrument to assess the understandability and actionability of print and audiovisual patient education materials.

- National Library of Medicine Health Literacy Webpage - Network of the National Library of Medicine health literacy webpage, including overview of definitions, research findings, prevalence and impact.

- PlainLanguage.gov – U.S. government website of the Plain Language Action and Information Network (PLAIN), a community of federal employees dedicated to the idea that citizens deserve clear communications from government. Includes information on laws and regulations, guidelines, examples, training and resources.

- Limited English Proficiency Resources - details related to providing access to information and services for individuals who have difficulty communicating effectively in English.

- The Guide to Providing Effective Communication and Language Assistance Services - information for providing effective communication and language assistance services to culturally and linguistically diverse individuals receiving care and services, including strategies for communicating in a way that considers the cultural, health literacy, and language needs of your patients and their families.

- Census Bureau Reports at Least 350 Languages Spoken in U.S. Homes

- Executive Order 13166 - Improving Access to Services for Persons With Limited English Proficiency

E. Disparity Impact Statement

OMH's disparity impact strategy is a comprehensive data-driven approach for identifying and addressing health disparities to promote health equity for racial and ethnic minority populations. A Disparity Impact Statement refers to the demographic, cultural, and linguistic data that identify the population(s) in which health disparities exist and the quality improvement plan designed to address the noted disparities.

Agencies within the U.S. Department of Health and Human Services offer resources to support developing a Disparity Impact Statement, including the following:

- Building an Organizational Response to Health Disparities: Disparities Impact Statement
- Examples of Disparities Impact Statements

F. Considerations in Plans for Oversight of Federal Funds

To the maximum extent possible, the organization should segregate responsibilities for receipt and custody of cash and other assets; maintaining accounting records on the assets; and authorizing transactions. In the case of payroll activities, the organization, where possible, should segregate the timekeeping, payroll preparation, payroll approval, and payment functions.

Questions for consideration in developing a plan may include:

- Do the written internal controls provide for the segregation of responsibilities to provide an adequate system of checks and balances?
- Are specific officials designated to approve payrolls and other major transactions
- Does the time and accounting system track effort by cost objective?
- Are time distribution records maintained for all employees when his/her effort cannot be specifically identified to a particular program cost objective?
    - Do the procedures for cash receipts and disbursements include: Receipts are promptly logged in, restrictively endorsed, and deposited in an insured bank account?
    - Bank statements are promptly reconciled to the accounting records, and are reconciled by someone other than the individuals handling cash, disbursements and maintaining accounting records?
    - All disbursements (except petty cash or EFT disbursements) are made by pre-numbered checks?
    - Supporting documents (e.g., purchase orders, Invoices, etc.) accompany checks submitted for signature and are marked "paid" or otherwise prominently noted after payments are made?

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2020 List of Minority Serving Institutions

This list is based on 2020 data from the U.S. Department of Education. It includes institutions that qualify for MSI funding and those receiving MSI funding.

AANAPISI	Asian American Native American Pacific Islander-Serving Institutions
ANNH	Native Hawaiian-Serving Institutions
HBCU	Historically Black Colleges & Universities
HSI	Hispanic Serving Institutions
MSI	Minority Serving Institution
NASNTI	Native American-Serving Non-Tribal Institutions
PBI	Predominantly Black Institutions
Pri	Private
Pub	Public
TCU	Tribal Colleges and Universities

MSI Type	Institution	City	State/Territory	Type
ANNH	University of Alaska Fairbanks	Fairbanks	AK	Pub 4yr
ANNH	University of Alaska Southeast	Juneau	AK	Pub 4yr
ANNH & NASNTI	Alaska Christian College	Soldotna	AK	Pri 2yr
NASNTI	Alaska Pacific University	Anchorage	AK	Pri 4yr
TCU	Ilisagvik College	Barrow	AK	Pub 4yr
HBCU	Alabama Agricultural & Mechanical University	Normal	AL	Pub 4yr
HBCU	Alabama State University	Montgomery	AL	Pub 4yr
HBCU	Bishop State Community College	Mobile	AL	Pub 2yr
HBCU	Concordia College Alabama	Selma	AL	Pri 4yr
HBCU	Gadsden State Community College	Gadsden	AL	Pub 2yr
HBCU	H. Councill Trenholm State Community College	Montgomery	AL	Pub 2yr
HBCU	J. F. Drake State Community and Technical College	Huntsville	AL	Pub 2yr
HBCU	Lawson State Community College	Birmingham	AL	Pub 2yr
HBCU	Miles College	Fairfield	AL	Pri 4yr
HBCU	Oakwood University	Huntsville	AL	Pri 4yr
HBCU	Shelton State Community College	Tuscaloosa	AL	Pub 2yr
HBCU	Stillman College	Tuscaloosa	AL	Pri 4yr
HBCU	Talladega College	Talladega	AL	Pri 4yr
HBCU	Tuskegee University	Tuskegee	AL	Pri 4yr
PBI	Chattahoochee Valley Community College	Phenix City	AL	Pub 2yr
PBI	Faulkner University	Montgomery	AL	Pri 4yr
PBI	George Corley Wallace State Community College - Selma	Selma	AL	Pub 2yr
PBI	Herzing University - Birmingham	Birmingham	AL	Pri 4yr
PBI	Remington College - Mobile Campus	Mobile	AL	Pri 4yr
PBI	Selma University	Selma	AL	Pri 4yr
PBI	University of West Alabama	Livingston	AL	Pub 4yr
HBCU	Arkansas Baptist College	Little Rock	AR	Pri 4yr
HBCU	Philander Smith College	Little Rock	AR	Pri 4yr

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MSI Type	Institution	City	State/Territory	Type
HBCU	Shorter College	N Little Rock	AR	Pri 2yr
HBCU	University of Arkansas at Pine Bluff	Pine Bluff	AR	Pub 4yr
HSI	Cossatot Community College of the University of Arkansas	De Queen	AR	Pub 2yr
PBI	Arkansas State University Mid-South	West Memphis	AR	Pub 2yr
PBI	Southeast Arkansas College	Pine Bluff	AR	Pub 2yr
AANAPISI & ANNH	American Samoa Community College	PagoPago	AS	Pub 4yr
ANNH & NASNTI	CollegeAmerica - Flagstaff	Flagstaff	AZ	Pri 4yr
HSI	Arizona State University	Phoenix	AZ	Pub 4yr
HSI	Arizona Western College	Yuma	AZ	Pub 2yr
HSI	Central Arizona College	Coolidge	AZ	Pub 2yr
HSI	CollegeAmerica - Phoenix	Phoenix	AZ	Pri 4yr
HSI	Estrella Mountain Community College	Avondale	AZ	Pub 2yr
HSI	GateWay Community College	Phoenix	AZ	Pub 2yr
HSI	Glendale Community College	Glendale	AZ	Pub 2yr
HSI	Mesa Community College	Mesa	AZ	Pub 2yr
HSI	Phoenix College	Phoenix	AZ	Pub 2yr
HSI	Pima County Community College	Tucson	AZ	Pub 2yr
HSI	South Mountain Community College	Phoenix	AZ	Pub 2yr
HSI	University of Arizona (The)	Sierra Vista	AZ	Pub 4yr
HSI	University of Arizona (The)	Tucson	AZ	Pub 4yr
NASNTI	Northland Pioneer College	Holbrook	AZ	Pub 2yr
TCU	Dine College	Tsaile	AZ	Pub 4yr
TCU	Tohono O'odham Community College	Sells	AZ	Pub 2yr
AANAPISI	American River College	Sacramento	CA	Pub 2yr
AANAPISI	Bethesda University	Anaheim	CA	Pri 4yr
AANAPISI	City College of San Francisco	San Francisco	CA	Pub 2yr
AANAPISI	Coastline Community College	Fountain Valley	CA	Pub 2yr
AANAPISI	Coleman University	San Diego	CA	Pri 4yr
AANAPISI	College of Alameda	Alameda	CA	Pub 2yr
AANAPISI	Evergreen Valley College	San Jose	CA	Pub 2yr
AANAPISI	Folsom Lake College	Folsom	CA	Pub 2yr
AANAPISI	Grace Mission University	Fullerton	CA	Pri 4yr
AANAPISI	Homestead Schools	Torrance	CA	Pri 4yr

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MSI Type	Institution	City	State/Territory	Type
AANAPISI	Irvine Valley College	Irvine	CA	Pub 2yr
AANAPISI	Laney College	Oakland	CA	Pub 2yr
AANAPISI	Otis College of Art & Design	Los Angeles	CA	Pri 4yr
AANAPISI	Palo Alto University	Palo Alto	CA	Pri 4yr
AANAPISI	Presbyterian Theological Seminary in America	Santa Fe Springs	CA	Pri 4yr
AANAPISI	University of California, Davis	Davis	CA	Pub 4yr
AANAPISI	University of San Francisco	San Francisco	CA	Pri 4yr
AANAPISI	University of the Pacific	Stockton	CA	Pri 4yr
AANAPISI & HSI	Azusa Pacific University	Azusa	CA	Pri 4yr
AANAPISI & HSI	Berkeley City College	Berkeley	CA	Pub 2yr
AANAPISI & HSI	California College San Diego	San Diego	CA	Pri 4yr
AANAPISI & HSI	California State Polytechnic University, Pomona	Pomona	CA	Pub 4yr
AANAPISI & HSI	California State University - Sacramento	Sacramento	CA	Pub 4yr
AANAPISI & HSI	California State University, East Bay	Hayward	CA	Pub 4yr
AANAPISI & HSI	California State University, Los Angeles	Los Angeles	CA	Pub 4yr
AANAPISI & HSI	California State University, Stanislaus	Turlock	CA	Pub 4yr
AANAPISI & HSI	Casa Loma College	Van Nuys	CA	Pri 2yr
AANAPISI & HSI	Clovis Community College	Fresno	CA	Pub 2yr
AANAPISI & HSI	College of San Mateo	San Mateo	CA	Pub 2yr
AANAPISI & HSI	Contra Costa College	San Pablo	CA	Pub 2yr
AANAPISI & HSI	Cosumnes River College	Sacramento	CA	Pub 2yr
AANAPISI & HSI	Cypress College	Cypress	CA	Pub 4yr
AANAPISI & HSI	El Camino College	Torrance	CA	Pub 2yr
AANAPISI & HSI	Golden West College	Huntington Beach	CA	Pub 2yr
AANAPISI & HSI	Holy Names University	Oakland	CA	Pri 4yr
AANAPISI & HSI	Humphreys University	Stockton	CA	Pri 4yr
AANAPISI & HSI	Long Beach City College	Long Beach	CA	Pub 2yr
AANAPISI & HSI	Los Angeles City College	Los Angeles	CA	Pub 2yr
AANAPISI & HSI	Los Medanos College	Pittsburg	CA	Pub 2yr
AANAPISI & HSI	Merritt College	Oakland	CA	Pub 2yr
AANAPISI & HSI	Mission College	Santa Clara	CA	Pub 2yr
AANAPISI & HSI	Mount Saint Mary's University	Los Angeles	CA	Pri 4yr
AANAPISI & HSI	Mount San Antonio College	Walnut	CA	Pub 2yr

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This list is based on 2020 data from the U.S. Department of Education. It includes institutions that qualify for MSI funding and those receiving MSI funding.

MSI Type	Institution	City	State/Territory	Type
AANAPISI & HSI	National University	La Jolla	CA	Pri 4yr
AANAPISI & HSI	Orange Coast College	Costa Mesa	CA	Pub 2yr
AANAPISI & HSI	Pacific Union College	Angwin	CA	Pri 4yr
AANAPISI & HSI	Saint Mary's College of California	Moraga	CA	Pri 4yr
AANAPISI & HSI	San Diego State University	San Diego	CA	Pub 4yr
AANAPISI & HSI	San Francisco State University	San Francisco	CA	Pub 4yr
AANAPISI & HSI	San Joaquin Delta College	Stockton	CA	Pub 2yr
AANAPISI & HSI	San Jose State University	San Jose	CA	Pub 4yr
AANAPISI & HSI	Solano Community College	Fairfield	CA	Pub 4yr
AANAPISI & HSI	University of California, Irvine	Irvine	CA	Pub 4yr
AANAPISI & HSI	University of California, Merced	Merced	CA	Pub 4yr
AANAPISI & HSI	University of California, Riverside	Riverside	CA	Pub 4yr
AANAPISI & HSI	Woodland Community College	Woodland	CA	Pub 2yr
AANAPISI & HSI	Yuba College	Marysville	CA	Pub 2yr
HSI	Allan Hancock College	Santa Maria	CA	Pub 2yr
HSI	Antelope Valley College	Lancaster	CA	Pub 4yr
HSI	Azusa Pacific University College	San Dimas	CA	Pri 4yr
HSI	Bakersfield College	Bakersfield	CA	Pub 4yr
HSI	Butte College	Oroville	CA	Pub 2yr
HSI	Cabrillo College	Aptos	CA	Pub 2yr
HSI	California Baptist University	Riverside	CA	Pri 4yr
HSI	California College San Diego	San Marcos	CA	Pri 4yr
HSI	California Lutheran University	Thousand Oaks	CA	Pri 4yr
HSI	California State University Channel Islands	Camarillo	CA	Pub 4yr
HSI	California State University, Bakersfield	Bakersfield	CA	Pub 4yr
HSI	California State University, Chico	Chico	CA	Pub 4yr
HSI	California State University, Dominguez Hills	Carson	CA	Pub 4yr
HSI	California State University, Fresno	Fresno	CA	Pub 4yr
HSI	California State University, Fullerton	Fullerton	CA	Pub 4yr
HSI	California State University, Long Beach	Long Beach	CA	Pub 4yr
HSI	California State University, Monterey Bay	Seaside	CA	Pub 4yr
HSI	California State University, Northridge	Northridge	CA	Pub 4yr
HSI	California State University, San Bernardino	San Bernardino	CA	Pub 4yr

2020 List of Minority Serving Institutions

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MSI Type	Institution	City	State/Territory	Type
HSI	California State University, San Marcos	San Marcos	CA	Pub 4yr
HSI	Canada College	Redwood City	CA	Pub 2yr
HSI	Cerritos Community College	Norwalk	CA	Pub 2yr
HSI	Cerro Coso Community College	Ridgecrest	CA	Pub 2yr
HSI	Chabot College	Hayward	CA	Pub 2yr
HSI	Chaffey Community College	Rancho Cucamonga	CA	Pub 2yr
HSI	Citrus Community College	Glendora	CA	Pub 2yr
HSI	College of the Canyons	Santa Clarita	CA	Pub 2yr
HSI	College of the Desert	Palm Desert	CA	Pub 2yr
HSI	College of the Sequoias	Visalia	CA	Pub 2yr
HSI	Copper Mountain College	Joshua Tree	CA	Pub 2yr
HSI	Cuesta College	San Luis Obispo	CA	Pub 2yr
HSI	Cuyamaca College	El Cajon	CA	Pub 2yr
HSI	Diablo Valley College	Pleasant Hill	CA	Pub 2yr
HSI	East Los Angeles College	Monterey Park	CA	Pub 2yr
HSI	East San Gabriel Valley ROP and Technical Center	West Covina	CA	Pub 2yr
HSI	Fresno City College	Fresno	CA	Pub 2yr
HSI	Fresno Pacific University	Fresno	CA	Pri 4yr
HSI	Gavilan College	Gilroy	CA	Pub 2yr
HSI	Glendale Community College	Glendale	CA	Pub 2yr
HSI	Grossmont College	El Cajon	CA	Pub 2yr
HSI	Hartnell Community College	Salinas	CA	Pub 2yr
HSI	Hope International University	Fullerton	CA	Pri 4yr
HSI	Humboldt State University	Arcata	CA	Pub 4yr
HSI	Imperial Valley College	Imperial	CA	Pub 2yr
HSI	John F. Kennedy University	Pleasant Hill	CA	Pri 4yr
HSI	La Sierra University	Riverside	CA	Pri 4yr
HSI	Lake Tahoe Community College	South Lake Tahoe	CA	Pub 2yr
HSI	Las Positas College	Livermore	CA	Pub 2yr
HSI	Life Pacific College	San Dimas	CA	Pri 4yr
HSI	Los Angeles Harbor College	Wilmington	CA	Pub 2yr
HSI	Los Angeles Mission College	Sylmar	CA	Pub 2yr
HSI	Los Angeles ORT College - Van Nuys Campus	Van Nuys	CA	Pri 2yr

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MSI Type	Institution	City	State/Territory	Type
HSI	Los Angeles Pierce College	Woodland Hills	CA	Pub 2yr
HSI	Los Angeles Trade - Technical College	Los Angeles	CA	Pub 2yr
HSI	Los Angeles Valley College	Valley Glen	CA	Pub 2yr
HSI	Marymount California University	Rancho Palos Verdes	CA	Pri 4yr
HSI	Mendocino College	Ukiah	CA	Pub 2yr
HSI	Mills College	Oakland	CA	Pri 4yr
HSI	Modesto Junior College	Modesto	CA	Pub 4yr
HSI	Monterey Peninsula College	Monterey	CA	Pub 2yr
HSI	Moorpark College	Moorpark	CA	Pub 2yr
HSI	Moreno Valley College	Moreno Valley	CA	Pub 2yr
HSI	Mt. San Jacinto College	San Jacinto	CA	Pub 2yr
HSI	Napa Valley College	Napa	CA	Pub 2yr
HSI	Norco College	Norco	CA	Pub 2yr
HSI	Notre Dame de Namur University	Belmont	CA	Pri 4yr
HSI	Oxnard College	Oxnard	CA	Pub 2yr
HSI	Palomar College	San Marcos	CA	Pub 2yr
HSI	Pasadena City College	Pasadena	CA	Pub 2yr
HSI	Porterville College	Porterville	CA	Pub 2yr
HSI	Reedley College	Reedley	CA	Pub 2yr
HSI	Rio Hondo Community College	Whittier	CA	Pub 4yr
HSI	Riverside City College	Riverside	CA	Pub 2yr
HSI	Sacramento City College	Sacramento	CA	Pub 2yr
HSI	Saddleback College	Mission Viejo	CA	Pub 2yr
HSI	San Bernardino Valley College	San Bernardino	CA	Pub 2yr
HSI	San Diego Christian College	Santee	CA	Pri 4yr
HSI	San Diego City College	San Diego	CA	Pub 2yr
HSI	San Diego Mesa College	San Diego	CA	Pub 4yr
HSI	San Jose City College	San Jose	CA	Pub 2yr
HSI	Santa Ana College	Santa Ana	CA	Pub 4yr
HSI	Santa Barbara City College	Santa Barbara	CA	Pub 2yr
HSI	Santa Monica College	Santa Monica	CA	Pub 4yr
HSI	Santa Rosa Junior College	Santa Rosa	CA	Pub 2yr
HSI	Santiago Canyon College	Orange	CA	Pub 2yr

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MSI Type	Institution	City	State/Territory	Type
HSI	Sierra College	Rocklin	CA	Pub 2yr
HSI	Skyline College	San Bruno	CA	Pub 4yr
HSI	Sonoma State University	Rohnert Park	CA	Pub 4yr
HSI	Southwestern Community College District	Chula Vista	CA	Pub 2yr
HSI	Taft College	Taft	CA	Pub 2yr
HSI	University of California, Santa Barbara	Santa Barbara	CA	Pub 4yr
HSI	University of California, Santa Cruz	Santa Cruz	CA	Pub 4yr
HSI	University of La Verne	La Verne	CA	Pri 4yr
HSI	Vanguard University of Southern California	Costa Mesa	CA	Pri 4yr
HSI	Ventura College	Ventura	CA	Pub 2yr
HSI	Victor Valley Community College	Victorville	CA	Pub 2yr
HSI	West Hills College Lemoore	Lemoore	CA	Pub 2yr
HSI	West Hills Community College	Coalinga	CA	Pub 2yr
HSI	West Los Angeles College	Culver City	CA	Pub 4yr
HSI	Whittier College	Whittier	CA	Pri 4yr
HSI	Woodbury University	Burbank	CA	Pri 4yr
ANNH & NASNTI	Fort Lewis College	Durango	CO	Pub 4yr
HSI	Adams State University	Alamosa	CO	Pub 4yr
HSI	Colorado State University - Pueblo	Pueblo	CO	Pub 4yr
HSI	Community College of Aurora	Aurora	CO	Pub 2yr
HSI	Community College of Denver	Denver	CO	Pub 4yr
HSI	Lamar Community College	Lamar	CO	Pub 2yr
HSI	Metropolitan State University of Denver	Denver	CO	Pub 4yr
HSI	Morgan Community College	Fort Morgan	CO	Pub 2yr
HSI	Pueblo Community College	Pueblo	CO	Pub 4yr
HSI	Trinidad State Junior College	Trinidad	CO	Pub 2yr
AANAPISI	University of Connecticut - Hartford Campus	Hartford	CT	Pub 4yr
HSI	Capital Community College	Hartford	CT	Pub 2yr
HSI	Gateway Community College	New Haven	CT	Pub 2yr
HSI	Naugatuck Valley Community College	Waterbury	CT	Pub 2yr
HSI	Norwalk Community College	Norwalk	CT	Pub 2yr
HBCU	Howard University	Washington	DC	Pri 4yr
HBCU	University of the District of Columbia	Washington	DC	Pub 4yr

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MSI Type	Institution	City	State/Territory	Type
PBI	Trinity Washington University	Washington	DC	Pri 4yr
HBCU	Delaware State University	Dover	DE	Pub 4yr
HBCU	Bethune Cookman University	Daytona Beach	FL	Pri 4yr
HBCU	Edward Waters College	Jacksonville	FL	Pri 4yr
HBCU	Florida Agricultural & Mechanical University	Tallahassee	FL	Pub 4yr
HBCU	Florida Memorial University	Miami Gardens	FL	Pri 4yr
HSI	Barry University	Miami	FL	Pri 4yr
HSI	Broward College	Fort Lauderdale	FL	Pub 4yr
HSI	Carlos Albizu University	Miami	FL	Pri 4yr
HSI	City College - Miami	Miami	FL	Pri 4yr
HSI	Florida Atlantic University	Boca Raton	FL	Pub 4yr
HSI	Florida International University	Miami	FL	Pub 4yr
HSI	Herzing University - Winter Park	Winter Park	FL	Pri 4yr
HSI	Hillsborough Community College	Tampa	FL	Pub 2yr
HSI	Hodges University	Naples	FL	Pri 4yr
HSI	Keiser University	Fort Lauderdale	FL	Pri 4yr
HSI	Miami Dade College	Miami	FL	Pub 4yr
HSI	Nova Southeastern University	Fort Lauderdale	FL	Pri 4yr
HSI	Palm Beach State College	Lake Worth	FL	Pub 4yr
HSI	Seminole State College of Florida	Sanford	FL	Pub 4yr
HSI	South Florida State College	Avon Park	FL	Pub 4yr
HSI	Trinity International University - Florida	Miramar	FL	Pri 4yr
HSI	Universidad Politecnica de Puerto Rico	Orlando	FL	Pri 4yr
HSI	Universidad Politecnica de Puerto Rico	Miami	FL	Pri 4yr
HSI	University of Central Florida	Orlando	FL	Pub 4yr
HSI	Valencia College	Orlando	FL	Pub 4yr
HSI & PBI	Altierus Career College	Tampa	FL	Pri 4yr
PBI	City College	Fort Lauderdale	FL	Pri 4yr
PBI	City College - Gainesville	Gainesville	FL	Pri 4yr
PBI	Everest University - Brandon	Tampa	FL	Pri 4yr
PBI	Everest University - South Orlando	Tampa	FL	Pri 4yr
PBI	Remington College - Heathrow Campus	Lake Mary	FL	Pri 4yr
PBI	University of Fort Lauderdale	Lauderhill	FL	Pri 4yr

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AANAPISI & ANNH	College of Micronesia - FSM	Pohnpei	FM	Pub 2yr
AANAPISI	Georgia Gwinnett College	Lawrenceville	GA	Pub 4yr
AANAPISI & PBI	Beulah Heights University	Atlanta	GA	Pri 4yr
AANAPISI & PBI	Georgia State University	Atlanta	GA	Pub 4yr
HBCU	Albany State University	Albany	GA	Pub 4yr
HBCU	Clark Atlanta University	Atlanta	GA	Pri 4yr
HBCU	Fort Valley State University	Fort Valley	GA	Pub 4yr
HBCU	Morehouse College	Atlanta	GA	Pri 4yr
HBCU	Paine College	Augusta	GA	Pri 4yr
HBCU	Savannah State University	Savannah	GA	Pub 4yr
HBCU	Spelman College	Atlanta	GA	Pri 4yr
HSI	Dalton State College	Dalton	GA	Pub 4yr
HSI & PBI	Altierus Career College - Norcross	Norcross	GA	Pri 2yr
PBI	Albany Technical College	Albany	GA	Pub 2yr
PBI	Atlanta Metropolitan State College	Atlanta	GA	Pub 4yr
PBI	Atlanta Technical College	Atlanta	GA	Pub 2yr
PBI	Augusta Technical College	Augusta	GA	Pub 2yr
PBI	Bainbridge State College	Bainbridge	GA	Pub 4yr
PBI	Central Georgia Technical College	Warner Robins	GA	Pub 2yr
PBI	Clayton State University	Morrow	GA	Pub 4yr
PBI	Columbus Technical College	Columbus	GA	Pub 2yr
PBI	East Georgia State College	Swainsboro	GA	Pub 4yr
PBI	Georgia Military College	Milledgeville	GA	Pub 4yr
PBI	Georgia Piedmont Technical College	Clarkston	GA	Pub 2yr
PBI	Georgia State University - Perimeter College	Atlanta	GA	Pub 2yr
PBI	Gupton - Jones College	Decatur	GA	Pri 2yr
PBI	Herzing University - Atlanta	Atlanta	GA	Pri 4yr
PBI	Oconee Fall Line Technical College	Sandersville	GA	Pub 2yr
PBI	Savannah Technical College	Savannah	GA	Pub 2yr
PBI	Shorter University - College of Adult & Professional Programs	Marietta	GA	Pri 4yr
PBI	South Georgia Technical College	Americus	GA	Pub 2yr
PBI	Southern Crescent Technical College	Griffin	GA	Pub 2yr
AANAPISI & ANNH	Pacific Islands University	Mangilao	GU	Pri 4yr

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MSI Type	Institution	City	State/Territory	Type
AANAPISI & ANNH	University of Guam	Mangilao	GU	Pub 4yr
AANAPISI	Hawaii Community College	Hilo	HI	Pub 2yr
AANAPISI	Hawaii Pacific University	Honolulu	HI	Pri 4yr
AANAPISI & ANNH	Honolulu Community College	Honolulu	HI	Pub 2yr
AANAPISI & ANNH	Kauai Community College	Lihue	HI	Pub 2yr
AANAPISI & ANNH	Pacific Rim Christian University	Honolulu	HI	Pri 4yr
AANAPISI & ANNH	Remington College - Honolulu Campus	Honolulu	HI	Pri 4yr
AANAPISI & ANNH	University of Hawaii at Hilo	Hilo	HI	Pub 4yr
ANNH	Chaminade University of Honolulu	Honolulu	HI	Pri 4yr
ANNH	Kapiolani Community College	Honolulu	HI	Pub 2yr
ANNH	Leeward Community College	Pearl City	HI	Pub 2yr
ANNH	University of Hawaii - West Oahu	Kapolei	HI	Pub 4yr
ANNH	University of Hawaii at Manoa	Honolulu	HI	Pub 4yr
ANNH	University of Hawaii Maui College	Kahului	HI	Pub 4yr
ANNH	Windward Community College	Kaneohe	HI	Pub 2yr
HSI	Stevens-Henager College	Idaho Falls	ID	Pri 4yr
AANAPISI	College of Du Page	Glen Ellyn	IL	Pub 2yr
AANAPISI	National University of Health Sciences (The)	Lombard	IL	Pri 4yr
AANAPISI	Oakton Community College	Des Plaines	IL	Pub 2yr
AANAPISI	Resurrection University	Chicago	IL	Pri 4yr
AANAPISI & HSI	University of Illinois at Chicago	Chicago	IL	Pub 4yr
HSI	American Academy of Art	Chicago	IL	Pri 4yr
HSI	Aurora University	Aurora	IL	Pri 4yr
HSI	City Colleges of Chicago Harry S Truman College	Chicago	IL	Pub 2yr
HSI	College of Lake County	Grayslake	IL	Pub 2yr
HSI	Concordia University	River Forest	IL	Pri 4yr
HSI	Dominican University	River Forest	IL	Pri 4yr
HSI	Harold Washington College	Chicago	IL	Pub 2yr
HSI	MacCormac College	Chicago	IL	Pri 2yr
HSI	Morton College	Cicero	IL	Pub 2yr
HSI	National Louis University	Chicago	IL	Pri 4yr
HSI	Northeastern Illinois University	Chicago	IL	Pub 4yr
HSI	Richard J Daley College - City Colleges of Chicago	Chicago	IL	Pub 2yr

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MSI Type	Institution	City	State/Territory	Type
HSI	Robert Morris University Illinois	Chicago	IL	Pri 4yr
HSI	Roosevelt University	Chicago	IL	Pri 4yr
HSI	Saint Augustine College	Chicago	IL	Pri 4yr
HSI	Saint Xavier University	Chicago	IL	Pri 4yr
HSI	Triton College	River Grove	IL	Pub 2yr
HSI	Waubonsee Community College	Sugar Grove	IL	Pub 2yr
HSI	Wilbur Wright College	Chicago	IL	Pub 2yr
HSI & PBI	City Colleges of Chicago - Malcolm X College	Chicago	IL	Pub 2yr
PBI	Chicago State University	Chicago	IL	Pub 4yr
PBI	City Colleges of Chicago - Kennedy King College	Chicago	IL	Pub 2yr
PBI	East-West University	Chicago	IL	Pri 4yr
PBI	Lincoln College	Lincoln	IL	Pri 4yr
PBI	Olive-Harvey College	Chicago	IL	Pub 2yr
PBI	Prairie State College	Chicago Heights	IL	Pub 2yr
PBI	South Suburban College of Cook County	South Holland	IL	Pub 2yr
HSI	Calumet College of Saint Joseph	Whiting	IN	Pri 4yr
PBI	Martin University	Indianapolis	IN	Pri 4yr
HSI	Dodge City Community College	Dodge City	KS	Pub 2yr
HSI	Donnelly College	Kansas City	KS	Pri 4yr
HSI	Garden City Community College	Garden City	KS	Pub 2yr
HSI	Seward County Community College	Liberal	KS	Pub 2yr
TCU	Haskell Indian Nations University	Lawrence	KS	Pub 4yr
HBCU	Kentucky State University	Frankfort	KY	Pub 4yr
HBCU	Simmons College of Kentucky	Louisville	KY	Pri 4yr
HBCU	Dillard University	New Orleans	LA	Pri 4yr
HBCU	Grambling State University	Grambling	LA	Pub 4yr
HBCU	Southern University and Agricultural & Mechanical College at Baton Rouge	Baton Rouge	LA	Pub 4yr
HBCU	Southern University at New Orleans	New Orleans	LA	Pub 4yr
HBCU	Southern University at Shreveport - Bossier City	Shreveport	LA	Pub 2yr
HBCU	Xavier University of Louisiana	New Orleans	LA	Pri 4yr
PBI	Baton Rouge Community College	Baton Rouge	LA	Pub 2yr
PBI	Delgado Community College	New Orleans	LA	Pub 2yr
PBI	Herzing University - Kenner	Kenner	LA	Pri 4yr

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MSI Type	Institution	City	State/Territory	Type
PBI	Remington College - Baton Rouge Campus	Baton Rouge	LA	Pri 2yr
PBI	Remington College - Lafayette Campus	Lafayette	LA	Pri 2yr
PBI	Remington College - Shreveport Campus	Shreveport	LA	Pri 4yr
PBI	South Louisiana Community College	Lafayette	LA	Pub 2yr
AANAPISI	Benjamin Franklin Institute of Technology	Boston	MA	Pub 4yr
AANAPISI	Bunker Hill Community College	Boston	MA	Pub 2yr
AANAPISI	Middlesex Community College	Bedford	MA	Pub 2yr
AANAPISI	University of Massachusetts - Boston	Boston	MA	Pub 4yr
HSI	Cambridge College	Boston	MA	Pri 4yr
HSI	Holyoke Community College	Holyoke	MA	Pub 2yr
HSI	Northern Essex Community College	Haverhill	MA	Pub 2yr
HSI	Springfield Technical Community College	Springfield	MA	Pub 2yr
AANAPISI	Montgomery College	Rockville	MD	Pub 2yr
AANAPISI	University of Maryland - Baltimore County	Baltimore	MD	Pub 4yr
HBCU	Bowie State University	Bowie	MD	Pub 4yr
HBCU	Coppin State University	Baltimore	MD	Pub 4yr
HBCU	Morgan State University	Baltimore	MD	Pub 4yr
HBCU	University of Maryland - Eastern Shore	Princess Anne	MD	Pub 4yr
PBI	Faith Theological Seminary	Baltimore	MD	Pri 4yr
PBI	Prince George's Community College	Largo	MD	Pub 2yr
PBI	University of Baltimore	Baltimore	MD	Pub 4yr
PBI	Washington Adventist University	Takoma Park	MD	Pri 4yr
AANAPISI	Andrews University	Berrien Springs	MI	Pri 4yr
PBI	Wayne County Community College District	Detroit	MI	Pub 2yr
TCU	Bay Mills Community College	Brimley	MI	Pub 2yr
TCU	Keweenaw Bay Ojibwa Community College	Baraga	MI	Pub 2yr
TCU	Saginaw Chippewa Tribal College	Mount Pleasant	MI	Pub 2yr
AANAPISI	Century College	White Bear Lake	MN	Pub 2yr
AANAPISI	Herzing University - Minneapolis	Minneapolis	MN	Pri 4yr
AANAPISI	Metropolitan State University	Saint Paul	MN	Pub 4yr
AANAPISI	North Hennepin Community College	Brooklyn Park	MN	Pub 2yr
AANAPISI	Saint Paul College - A Community & Technical College	Saint Paul	MN	Pub 2yr
AANAPISI	St. Catherine University	Saint Paul	MN	Pri 4yr

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AANAPISI	University of Minnesota - Twin Cities	Minneapolis	MN	Pub 4yr
NASNTI	University of Minnesota - Morris	Morris	MN	Pub 4yr
TCU	Fond du Lac Tribal & Community College	Cloquet	MN	Pub 2yr
TCU	Leech Lake Tribal College	Cass Lake	MN	Pub 2yr
TCU	White Earth Tribal and Community College	Mahnomen	MN	Pri 2yr
HBCU	Harris - Stowe State University	Saint Louis	MO	Pub 4yr
HBCU	Lincoln University	Jefferson City	MO	Pub 4yr
PBI	TechMission	Kansas City	MO	Pri 4yr
AANAPISI & ANNH	Northern Marianas College	Saipan	MP	Pub 4yr
HBCU	Alcorn State University	Alcorn State	MS	Pub 4yr
HBCU	Coahoma Community College	Clarksdale	MS	Pub 2yr
HBCU	Jackson State University	Jackson	MS	Pub 4yr
HBCU	Mississippi Valley State University	Itta Bena	MS	Pub 4yr
HBCU	Rust College	Holly Springs	MS	Pri 4yr
HBCU	Tougaloo College	Tougaloo	MS	Pri 4yr
PBI	Belhaven University	Jackson	MS	Pri 4yr
PBI	East Mississippi Community College	Scooba	MS	Pub 2yr
PBI	Hinds Community College	Raymond	MS	Pub 2yr
PBI	Holmes Community College	Goodman	MS	Pub 2yr
PBI	Meridian Community College	Meridian	MS	Pub 2yr
PBI	Mississippi Delta Community College	Moorhead	MS	Pub 2yr
PBI	Southeastern Baptist College	Laurel	MS	Pri 4yr
PBI	Southwest Mississippi Community College	Summit	MS	Pub 2yr
NASNTI	Montana State University - Northern	Havre	MT	Pub 4yr
TCU	Aaniiih Nakoda College	Harlem	MT	Pub 2yr
TCU	Blackfeet Community College	Browning	MT	Pri 2yr
TCU	Chief Dull Knife College	Lame Deer	MT	Pub 2yr
TCU	Fort Peck Community College	Poplar	MT	Pub 2yr
TCU	Little Big Horn College	Crow Agency	MT	Pub 2yr
TCU	Salish Kootenai College	Pablo	MT	Pri 4yr
TCU	Stone Child College	Box Elder	MT	Pub 4yr
AANAPISI & ANNH	Pamlico Community College	Grantsboro	NC	Pub 2yr
ANNH & NASNTI	Robeson Community College	Lumberton	NC	Pub 2yr

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HBCU	Bennett College	Greensboro	NC	Pri 4yr
HBCU	Elizabeth City State University	Elizabeth City	NC	Pub 4yr
HBCU	Fayetteville State University	Fayetteville	NC	Pub 4yr
HBCU	Johnson C Smith University	Charlotte	NC	Pri 4yr
HBCU	Livingstone College	Salisbury	NC	Pri 4yr
HBCU	North Carolina Agricultural & Technical State University	Greensboro	NC	Pub 4yr
HBCU	North Carolina Central University	Durham	NC	Pub 4yr
HBCU	Saint Augustine's University	Raleigh	NC	Pri 4yr
HBCU	Shaw University	Raleigh	NC	Pri 4yr
HBCU	Winston-Salem State University	Winston-Salem	NC	Pub 4yr
HSI	Sampson Community College	Clinton	NC	Pub 2yr
NASNTI	Bladen Community College	Dublin	NC	Pub 2yr
NASNTI	University of North Carolina at Pembroke	Pembroke	NC	Pub 4yr
PBI	Carolina College of Biblical Studies	Fayetteville	NC	Pri 4yr
PBI	Charlotte Christian College and Theological Seminary	Charlotte	NC	Pri 4yr
PBI	Chowan University	Murfreesboro	NC	Pri 4yr
PBI	Edgecombe Community College	Tarboro	NC	Pub 2yr
PBI	Halifax Community College	Weldon	NC	Pub 2yr
PBI	Johnson & Wales University - Charlotte	Charlotte	NC	Pri 4yr
PBI	North Carolina Wesleyan College	Rocky Mount	NC	Pri 4yr
TCU	Cankdeska Cikana (Little Hoop) Community College	Fort Totten	ND	Pub 2yr
TCU	Nueta Hidatsa Sahnish College	New Town	ND	Pub 4yr
TCU	Sitting Bull College	Fort Yates	ND	Pub 4yr
TCU	Turtle Mountain Community College	Belcourt	ND	Pri 4yr
TCU	United Tribes Technical College	Bismarck	ND	Pri 4yr
TCU	Little Priest Tribal College	Winnebago	NE	Pub 2yr
TCU	Nebraska Indian Community College	Macy	NE	Pub 2yr
AANAPISI & HSI	Rutgers, the State University of New Jersey	Newark	NJ	Pub 4yr
HSI	Bergen Community College	Paramus	NJ	Pub 2yr
HSI	College of Saint Elizabeth	Morristown	NJ	Pri 4yr
HSI	Cumberland County College	Vineland	NJ	Pub 2yr
HSI	Fairleigh Dickinson University	Teaneck	NJ	Pri 4yr
HSI	Felician University	Lodi	NJ	Pri 4yr

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HSI	Hudson County Community College	Jersey City	NJ	Pub 2yr
HSI	Kean University	Union	NJ	Pub 4yr
HSI	Montclair State University	Montclair	NJ	Pub 4yr
HSI	New Jersey City University	Jersey City	NJ	Pub 4yr
HSI	Passaic County Community College	Paterson	NJ	Pub 2yr
HSI	Pillar College	Newark	NJ	Pri 4yr
HSI	Saint Peter's University	Jersey City	NJ	Pri 4yr
HSI	Union County College	Cranford	NJ	Pub 2yr
HSI	William Paterson University of New Jersey	Wayne	NJ	Pub 4yr
HSI & PBI	Bloomfield College	Bloomfield	NJ	Pri 4yr
HSI & PBI	Essex County College	Newark	NJ	Pub 2yr
ANNH & NASNTI	San Juan College	Farmington	NM	Pub 2yr
HSI	Central New Mexico Community College	Albuquerque	NM	Pub 2yr
HSI	Clovis Community College	Clovis	NM	Pub 2yr
HSI	Eastern New Mexico University	Ruidoso	NM	Pub 2yr
HSI	Eastern New Mexico University	Roswell	NM	Pub 2yr
HSI	Eastern New Mexico University	Portales	NM	Pub 4yr
HSI	Mesalands Community College	Tucumcari	NM	Pub 2yr
HSI	New Mexico Highlands University	Las Vegas	NM	Pub 4yr
HSI	New Mexico Institute of Mining & Technology	Socorro	NM	Pub 4yr
HSI	New Mexico State University	Las Cruces	NM	Pub 4yr
HSI	New Mexico State University	Grants	NM	Pub 2yr
HSI	New Mexico State University	Las Cruces	NM	Pub 2yr
HSI	New Mexico State University	Carlsbad	NM	Pub 2yr
HSI	New Mexico State University	Alamogordo	NM	Pub 2yr
HSI	Northern New Mexico College	Espanola	NM	Pub 4yr
HSI	Santa Fe Community College	Santa Fe	NM	Pub 2yr
HSI	University of New Mexico	Los Lunas	NM	Pub 2yr
HSI	University of New Mexico	Ranchos de Taos	NM	Pub 2yr
HSI	University of New Mexico	Albuquerque	NM	Pub 4yr
HSI	University of New Mexico	Los Alamos	NM	Pub 2yr
HSI	University of the Southwest	Hobbs	NM	Pri 4yr
HSI	Western New Mexico University	Silver City	NM	Pub 4yr

2020 List of Minority Serving Institutions

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MSI Type	Institution	City	State/Territory	Type
NASNTI	Eastern New Mexico University	Ruidoso	NM	Pub 2yr
NASNTI	New Mexico State University	Grants	NM	Pub 2yr
TCU	Institute of American Indian & Alaska Native Culture & Arts Development	Santa Fe	NM	Pub 4yr
TCU	Navajo Technical University	Crownpoint	NM	Pub 4yr
TCU	Southwestern Indian Polytechnic Institute	Albuquerque	NM	Pub 2yr
AANAPISI	University of Nevada - Las Vegas	Las Vegas	NV	Pub 4yr
AANAPISI & HSI	College of Southern Nevada	Las Vegas	NV	Pub 4yr
HSI	Nevada State College	Henderson	NV	Pub 4yr
HSI	Western Nevada College	Carson City	NV	Pub 4yr
AANAPISI	Adelphi University	Garden City	NY	Pri 4yr
AANAPISI	CUNY Bernard M. Baruch College	New York	NY	Pub 4yr
AANAPISI	CUNY Brooklyn College	Brooklyn	NY	Pub 4yr
AANAPISI	Kingsborough Community College/CUNY	Brooklyn	NY	Pub 2yr
AANAPISI	Long Island University	Brooklyn	NY	Pri 4yr
AANAPISI	New York College of Health Professions	Syosset	NY	Pri 4yr
AANAPISI	New York Institute of Technology	Old Westbury	NY	Pri 4yr
AANAPISI	Saint John's University	Queens	NY	Pri 4yr
AANAPISI & HSI	City College of New York - CUNY	New York	NY	Pub 4yr
AANAPISI & HSI	College of Staten Island/CUNY	Staten Island	NY	Pub 4yr
AANAPISI & HSI	CUNY Hunter College	New York	NY	Pub 4yr
AANAPISI & HSI	CUNY Queens College	Queens	NY	Pub 4yr
AANAPISI & HSI	Queensborough Community College - CUNY	Bayside	NY	Pub 2yr
AANAPISI & HSI	SUNY College at Old Westbury	Old Westbury	NY	Pub 4yr
HSI	American Musical & Dramatic Academy	New York	NY	Pri 4yr
HSI	Boricua College	New York	NY	Pri 4yr
HSI	College of Mount Saint Vincent	Bronx	NY	Pri 4yr
HSI	CUNY Borough of Manhattan Community College	New York	NY	Pub 2yr
HSI	CUNY Bronx Community College	Bronx	NY	Pub 2yr
HSI	CUNY John Jay College of Criminal Justice	New York	NY	Pub 4yr
HSI	CUNY LaGuardia Community College	Long Island City	NY	Pub 2yr
HSI	CUNY Lehman College	Bronx	NY	Pub 4yr
HSI	CUNY, Hostos Community College	Bronx	NY	Pub 2yr
HSI	Dominican College of Blauvelt	Orangeburg	NY	Pri 4yr

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HSI	Long Island University - Riverhead	Riverhead	NY	Pri 4yr
HSI	Mercy College	Dobbs Ferry	NY	Pri 4yr
HSI	New York City College of Technology of the City University of New York	Brooklyn	NY	Pub 4yr
HSI	Nyack College	Nyack	NY	Pri 4yr
HSI	Orange County Community College	Middletown	NY	Pub 2yr
HSI	Rockland Community College	Suffern	NY	Pub 2yr
HSI	Stella and Charles Guttman Community College	New York	NY	Pub 2yr
HSI	SUNY Westchester Community College	Valhalla	NY	Pub 2yr
HSI	Vaughn College of Aeronautics and Technology	Flushing	NY	Pri 4yr
HSI & PBI	College of New Rochelle (The)	New Rochelle	NY	Pri 4yr
HSI & PBI	CUNY Graduate School & University Center	New York	NY	Pub 4yr
PBI	CUNY Medgar Evers College	Brooklyn	NY	Pub 4yr
PBI	CUNY York College	Jamaica	NY	Pub 4yr
PBI	Metropolitan College of New York	New York	NY	Pri 4yr
HBCU	Central State University	Wilberforce	OH	Pub 4yr
HBCU	Wilberforce University	Wilberforce	OH	Pri 4yr
HSI	Union Institute & University	Cincinnati	OH	Pri 4yr
PBI	Altierus Career College - Columbus	Gahanna	OH	Pri 2yr
PBI	Herzing University - Toledo	Toledo	OH	Pri 4yr
PBI	Remington College - Cleveland Campus	Cleveland	OH	Pri 2yr
ANNH & NASNTI	Bacone College	Muskogee	OK	Pri 4yr
ANNH & NASNTI	Carl Albert State College	Poteau	OK	Pub 2yr
ANNH & NASNTI	Connors State College	Warner	OK	Pub 2yr
HBCU	Langston University	Langston	OK	Pub 4yr
HSI	Oklahoma Panhandle State University	Goodwell	OK	Pub 4yr
NASNTI	Community Care College	Tulsa	OK	Pri 2yr
NASNTI	Northeastern Oklahoma A & M College	Miami	OK	Pub 2yr
NASNTI	Northeastern State University	Tahlequah	OK	Pub 4yr
NASNTI	Northern Oklahoma College	Tonkawa	OK	Pub 2yr
NASNTI	Oklahoma State University Institute of Technology - Okmulgee	Okmulgee	OK	Pub 4yr
NASNTI	Redlands Community College	El Reno	OK	Pub 2yr
NASNTI	Rogers State University	Claremore	OK	Pub 4yr
NASNTI	Seminole State College	Seminole	OK	Pub 2yr

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NASNTI	Southeastern Oklahoma State University	Durant	OK	Pub 4yr
TCU	College of the Muscogee Nation	Okmulgee	OK	Pub 2yr
AANAPISI	Pacific University	Forest Grove	OR	Pri 4yr
AANAPISI	Portland State University	Portland	OR	Pub 4yr
HSI	Blue Mountain Community College	Pendleton	OR	Pub 2yr
HSI	Chemeketa Community College	Salem	OR	Pub 2yr
HSI	Columbia Gorge Community College	The Dalles	OR	Pub 2yr
HSI	Treasure Valley Community College	Ontario	OR	Pub 2yr
HSI	Warner Pacific University	Portland	OR	Pri 4yr
AANAPISI	Pennsylvania State University - Penn State Abington	Abington	PA	Pub 4yr
HBCU	Cheyney University of Pennsylvania	Cheyney	PA	Pub 4yr
HBCU	Lincoln University	Lincoln University	PA	Pub 4yr
HSI	Eastern University	Saint Davids	PA	Pri 4yr
HSI	Reading Area Community College	Reading	PA	Pub 2yr
PBI	Community College of Philadelphia	Philadelphia	PA	Pub 2yr
PBI	Peirce College	Philadelphia	PA	Pri 4yr
HSI	American University of Puerto Rico	Bayamon	PR	Pri 4yr
HSI	Atenas College	Manati	PR	Pri 4yr
HSI	Atlantic University College	Guaynabo	PR	Pri 4yr
HSI	Caribbean University	Bayamon	PR	Pri 4yr
HSI	Caribbean University	Carolina	PR	Pri 4yr
HSI	Caribbean University	Ponce	PR	Pri 4yr
HSI	Caribbean University	Vega Baja	PR	Pri 4yr
HSI	Carlos Albizu University	San Juan	PR	Pri 4yr
HSI	Colegio Universitario de San Juan	San Juan	PR	Pub 4yr
HSI	Commonwealth of Puerto Rico Department of Education	San Juan	PR	Pub 2yr
HSI	Dewey University	Mayaguez	PR	Pri 2yr
HSI	Dewey University	Manati	PR	Pri 4yr
HSI	Dewey University	Juana Diaz	PR	Pri 4yr
HSI	Dewey University	Hato Rey	PR	Pri 4yr
HSI	Dewey University	Fajardo	PR	Pri 2yr
HSI	Dewey University	Carolina	PR	Pri 4yr
HSI	EDP University of Puerto Rico	San Juan	PR	Pri 4yr

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HSI	EDP University of Puerto Rico Inc - San Sebastian	San Sebastian	PR	Pri 4yr
HSI	Humacao Community College	Humacao	PR	Pri 4yr
HSI	Instituto Tecnologico de Puerto Rico - Recinto de Manati	Manati	PR	Pub 2yr
HSI	Inter American University of Puerto Rico - Aguadilla Campus	Aguadilla	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Arecibo Campus	Arecibo	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Barranquitas Campus	Barranquitas	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Bayamon Campus	Bayamon	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Fajardo Campus	Fajardo	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Guayama Campus	Guayama	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Metropolitan Campus	San Juan	PR	Pri 4yr
HSI	Inter American University of Puerto Rico - Ponce Campus	Mercedita	PR	Pri 4yr
HSI	Inter American University of Puerto Rico San German Campus	San German	PR	Pri 4yr
HSI	Pontifical Catholic University of Puerto Rico (The)	Ponce	PR	Pri 4yr
HSI	Pontifical Catholic University of Puerto Rico (The)	Mayaguez	PR	Pri 4yr
HSI	Pontifical Catholic University of Puerto Rico (The)	Arecibo	PR	Pri 4yr
HSI	San Juan Bautista School of Medicine	Caguas	PR	Pri 4yr
HSI	Trinity College of Puerto Rico	Ponce	PR	Pri 2yr
HSI	Universal Technology College of Puerto Rico	Aguadilla	PR	Pri 4yr
HSI	Universidad Adventista De Las Antillas	Mayaguez	PR	Pri 4yr
HSI	Universidad Ana G. Mendez - Gurabo Campus	Gurabo	PR	Pri 4yr
HSI	Universidad Ana G. Mendez, Carolina Campus	Carolina	PR	Pri 4yr
HSI	Universidad Ana G. Mendez, Cupey Campus	San Juan	PR	Pri 4yr
HSI	Universidad Central de Bayamon	Bayamón	PR	Pri 4yr
HSI	Universidad del Sagrado Corazón	Santurce	PR	Pri 4yr
HSI	Universidad Politécnica de Puerto Rico	Hato Rey	PR	Pri 4yr
HSI	University of Puerto Rico - Arecibo	Arecibo	PR	Pub 4yr
HSI	University of Puerto Rico - Cayey University College	Cayey	PR	Pub 4yr
HSI	University of Puerto Rico - Humacao University College	Humacao	PR	Pub 4yr
HSI	University of Puerto Rico - Mayaguez	Mayaguez	PR	Pub 4yr
HSI	University of Puerto Rico - Medical Science Campus	San Juan	PR	Pub 4yr
HSI	University of Puerto Rico - Rio Piedras Campus	San Juan	PR	Pub 4yr
HSI	University of Puerto Rico, Aguadilla Regional College	Aguadilla	PR	Pub 4yr
HBCU	Allen University	Columbia	SC	Pri 4yr

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HBCU	Benedict College	Columbia	SC	Pri 4yr
HBCU	Claflin University	Orangeburg	SC	Pri 4yr
HBCU	Clinton College	Rock Hill	SC	Pri 4yr
HBCU	Denmark Technical College	Denmark	SC	Pub 2yr
HBCU	Morris College	Sumter	SC	Pri 4yr
HBCU	South Carolina State University	Orangeburg	SC	Pub 4yr
HBCU	Voorhees College	Denmark	SC	Pri 4yr
PBI	Central Carolina Technical College	Sumter	SC	Pub 2yr
PBI	Florence - Darlington Technical College	Florence	SC	Pub 2yr
PBI	Limestone College	Gaffney	SC	Pri 4yr
PBI	Northeastern Technical College	Cheraw	SC	Pub 2yr
PBI	Orangeburg - Calhoun Technical College	Orangeburg	SC	Pub 2yr
PBI	Williamsburg Technical College	Kingstree	SC	Pub 2yr
NASNTI	Western Dakota Technical Institute	Rapid City	SD	Pub 2yr
TCU	Oglala Lakota College	Kyle	SD	Pub 4yr
TCU	Sinte Gleska University	Mission	SD	Pri 4yr
TCU	Sisseton Wahpeton College	Sisseton	SD	Pub 2yr
HBCU	American Baptist Theological Seminary	Nashville	TN	Pri 4yr
HBCU	Fisk University	Nashville	TN	Pri 4yr
HBCU	Lane College	Jackson	TN	Pri 4yr
HBCU	LeMoyne - Owen College	Memphis	TN	Pri 4yr
HBCU	Tennessee State University	Nashville	TN	Pub 4yr
PBI	Baptist Memorial College of Health Sciences	Memphis	TN	Pri 4yr
PBI	Remington College - Memphis Campus	Memphis	TN	Pri 4yr
PBI	Southwest Tennessee Community College	Memphis	TN	Pub 2yr
AANAPISI & HSI	Brookhaven College	Farmers Branch	TX	Pub 2yr
AANAPISI & HSI	Houston Community College	Houston	TX	Pub 2yr
AANAPISI & HSI	North Lake College	Irving	TX	Pub 2yr
AANAPISI & HSI	Richland College	Dallas	TX	Pub 2yr
AANAPISI & HSI	University of Houston	Houston	TX	Pub 4yr
AANAPISI & HSI	University of Saint Thomas	Houston	TX	Pri 4yr
AANAPISI & HSI	Wharton County Junior College	Wharton	TX	Pub 2yr
HBCU	Huston - Tillotson University	Austin	TX	Pri 4yr

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HBCU	Jarvis Christian College	Hawkins	TX	Pri 4yr
HBCU	Paul Quinn College	Dallas	TX	Pri 4yr
HBCU	Prairie View Agricultural & Mechanical University	Prairie View	TX	Pub 4yr
HBCU	Saint Philip's College	San Antonio	TX	Pub 2yr
HBCU	Southwestern Christian College	Terrell	TX	Pri 4yr
HBCU	Texas College	Tyler	TX	Pri 4yr
HBCU	Texas Southern University	Houston	TX	Pub 4yr
HBCU	Wiley College	Marshall	TX	Pri 4yr
HSI	Altierus Career College - Arlington	Arlington	TX	Pri 2yr
HSI	Altierus Career College - Fort Worth South	Ft Worth	TX	Pri 2yr
HSI	Alvin Community College	Alvin	TX	Pub 2yr
HSI	Amarillo College	Amarillo	TX	Pub 2yr
HSI	Angelina College	Lufkin	TX	Pub 2yr
HSI	Angelo State University	San Angelo	TX	Pub 4yr
HSI	Austin Community College	Austin	TX	Pub 2yr
HSI	Brazosport College	Lake Jackson	TX	Pub 4yr
HSI	Cisco College	Cisco	TX	Pub 2yr
HSI	Clarendon College	Clarendon	TX	Pub 2yr
HSI	Coastal Bend College	Beeville	TX	Pub 2yr
HSI	College of the Mainland	Texas City	TX	Pub 2yr
HSI	Concordia University Texas	Austin	TX	Pri 4yr
HSI	Del Mar College	Corpus Christi	TX	Pub 2yr
HSI	Eastfield College	Mesquite	TX	Pub 2yr
HSI	El Centro College	Dallas	TX	Pub 2yr
HSI	El Paso Community College	El Paso	TX	Pub 2yr
HSI	Frank Phillips College	Borger	TX	Pub 2yr
HSI	Galveston College	Galveston	TX	Pub 2yr
HSI	Hallmark University	San Antonio	TX	Pri 4yr
HSI	Houston Baptist University	Houston	TX	Pri 4yr
HSI	Howard County Junior College District	Big Spring	TX	Pub 2yr
HSI	Jacksonville College	Jacksonville	TX	Pri 2yr
HSI	Lamar State College - Port Arthur	Port Arthur	TX	Pub 2yr
HSI	Laredo College	Laredo	TX	Pub 2yr

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HSI	Lee College	Baytown	TX	Pub 2yr
HSI	Lone Star College System	The Woodlands	TX	Pub 2yr
HSI	McLennan Community College	Waco	TX	Pub 2yr
HSI	McMurry University	Abilene	TX	Pri 4yr
HSI	Mountain View College	Dallas	TX	Pub 2yr
HSI	Northeast Texas Community College	Mount Pleasant	TX	Pub 2yr
HSI	Northwest Vista College	San Antonio	TX	Pub 2yr
HSI	Odessa College	Odessa	TX	Pub 2yr
HSI	Our Lady of The Lake University	San Antonio	TX	Pri 4yr
HSI	Palo Alto College	San Antonio	TX	Pub 2yr
HSI	Remington College	Garland	TX	Pri 4yr
HSI	Remington College - Fort Worth Campus	Fort Worth	TX	Pri 4yr
HSI	Remington College - Houston Southeast Campus	Webster	TX	Pri 2yr
HSI	San Antonio College	San Antonio	TX	Pub 2yr
HSI	San Jacinto Community College District	Pasadena	TX	Pub 2yr
HSI	Schreiner University	Kerrville	TX	Pri 4yr
HSI	South Plains College	Levelland	TX	Pub 2yr
HSI	South Texas College	McAllen	TX	Pub 4yr
HSI	Southwest Texas Junior College	Uvalde	TX	Pub 2yr
HSI	Southwestern Adventist University	Keene	TX	Pri 4yr
HSI	St. Edward's University	Austin	TX	Pri 4yr
HSI	St. Mary's University	San Antonio	TX	Pri 4yr
HSI	Sul Ross State University	Alpine	TX	Pub 4yr
HSI	Tarrant County College District	Fort Worth	TX	Pub 2yr
HSI	Temple College	Temple	TX	Pub 2yr
HSI	Texas A&M International University	Laredo	TX	Pub 4yr
HSI	Texas A&M University - Corpus Christi	Corpus Christi	TX	Pub 4yr
HSI	Texas A&M University - Kingsville	Kingsville	TX	Pub 4yr
HSI	Texas A&M University - San Antonio	San Antonio	TX	Pub 4yr
HSI	Texas Lutheran University	Seguin	TX	Pri 4yr
HSI	Texas Southmost College	Brownsville	TX	Pub 2yr
HSI	Texas State Technical College	Waco	TX	Pub 2yr
HSI	Texas State University	San Marcos	TX	Pub 4yr

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HSI	Texas Tech University	Lubbock	TX	Pub 4yr
HSI	Texas Wesleyan University	Fort Worth	TX	Pri 4yr
HSI	Texas Woman's University	Denton	TX	Pub 4yr
HSI	University of Houston - Clear Lake	Houston	TX	Pub 4yr
HSI	University of Houston - Downtown	Houston	TX	Pub 4yr
HSI	University of Houston - Victoria	Victoria	TX	Pub 4yr
HSI	University of North Texas at Dallas	Dallas	TX	Pub 4yr
HSI	University of Texas - Rio Grande Valley	Edinburg	TX	Pub 4yr
HSI	University of Texas at Arlington	Arlington	TX	Pub 4yr
HSI	University of Texas at El Paso	El Paso	TX	Pub 4yr
HSI	University of Texas at San Antonio	San Antonio	TX	Pub 4yr
HSI	University of Texas Health Science Center at San Antonio	San Antonio	TX	Pub 4yr
HSI	University of Texas of the Permian Basin	Odessa	TX	Pub 4yr
HSI	University of the Incarnate Word	San Antonio	TX	Pri 4yr
HSI	Vernon College	Vernon	TX	Pub 2yr
HSI	Victoria College	Victoria	TX	Pub 2yr
HSI	Western Texas College	Snyder	TX	Pub 2yr
HSI & PBI	Altierus Career College - Bissonnet	Houston	TX	Pri 2yr
HSI & PBI	Cedar Valley College	Lancaster	TX	Pub 2yr
HSI & PBI	Remington College-North Houston Campus	Houston	TX	Pri 4yr
PBI	Dallas Nursing Institute	Dallas	TX	Pri 4yr
AANAPISI	Northern Virginia Community College	Annandale	VA	Pub 2yr
HBCU	Hampton University	Hampton	VA	Pri 4yr
HBCU	Norfolk State University	Norfolk	VA	Pub 4yr
HBCU	Virginia State University	Petersburg	VA	Pub 4yr
HBCU	Virginia Union University	Richmond	VA	Pri 4yr
HBCU	Virginia University of Lynchburg	Lynchburg	VA	Pri 4yr
HBCU	University of the Virgin Islands	Charlotte Amalie	VI	Pub 4yr
AANAPISI	Bastyr University	Kenmore	WA	Pri 4yr
AANAPISI	Bellevue College	Bellevue	WA	Pub 4yr
AANAPISI	Edmonds Community College	Lynnwood	WA	Pub 4yr
AANAPISI	Green River College	Auburn	WA	Pub 4yr
AANAPISI	Highline College	Des Moines	WA	Pub 4yr

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AANAPISI	Lake Washington Institute of Technology	Kirkland	WA	Pub 4yr
AANAPISI	Pierce College	Lakewood	WA	Pub 4yr
AANAPISI	Saint Martin's University	Lacey	WA	Pri 4yr
AANAPISI	Seattle Central College	Seattle	WA	Pub 4yr
AANAPISI	Shoreline Community College	Shoreline	WA	Pub 2yr
AANAPISI	University of Washington - Seattle	Bothell	WA	Pub 4yr
AANAPISI	University of Washington - Tacoma Campus	Tacoma	WA	Pub 4yr
HSI	Big Bend Community College	Moses Lake	WA	Pub 2yr
HSI	Columbia Basin College	Pasco	WA	Pub 4yr
HSI	Heritage University	Toppenish	WA	Pri 4yr
HSI	Perry Technical Institute	Yakima	WA	Pri 2yr
HSI	Wenatchee Valley College	Wenatchee	WA	Pub 4yr
HSI	Yakima Valley College	Yakima	WA	Pub 4yr
TCU	Northwest Indian College	Bellingham	WA	Pub 4yr
ANNH & NASNTI	East - West University	Keshena	WI	Pri 4yr
HSI	Alverno College	Milwaukee	WI	Pri 4yr
TCU	College of Menominee Nation	Keshena	WI	Pri 4yr
TCU	Lac Courte Oreilles Ojibwa Community College	Hayward	WI	Pub 2yr
HBCU	Bluefield State College	Bluefield	WV	Pub 4yr
HBCU	West Virginia State University	Institute	WV	Pub 4yr

CalOptima
A Public Agency
Better. Together.

April 15, 2021

Department of Health and Human Services
Office of the Assistant Secretary for Health

C/O Hieu Nguyen, LCSW, MBA
Director of Population Health & Equity
405 W. 5th Street
Santa Ana, CA 92706

Re: MP-CPI-21-006, Proposal for Advancing Health Literacy to Enhance Equitable Community Responses to Covid-19

To Whom It May Concern:

Orange County Health Authority, dba CalOptima, the county organized health system for the County of Orange, California, (CalOptima) is the county's Medi-Cal managed care plan. Pursuant to its contract with the California Department of Health Care Services (DHCS), CalOptima is obligated to arrange and pay for the provision of covered health care services to certain Medi-Cal-eligible beneficiaries in Orange County via the Medi-Cal program. Furthermore, CalOptima is also contracted with federal regulator the Centers for Medicare & Medicaid Services (CMS) and DHCS for three programs that primarily serve seniors, OneCare (HMO SNP), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

The Orange County Health Care Agency (OCHCA) has advised CalOptima that it plans to submit an application under the Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 Initiative. OCHCA intends to apply for a $4 million grant to target the needs of seniors with chronic conditions, specifically obesity and diabetes, and the providers serving them. OCHCA advised that most funding is expected to be distributed to community organizations and agencies, including Council on Aging, Multi-Ethnic Collaborative of Community Agencies (MECCA), Orange County Aging Services Collaborative, and Orange County Office on Aging. CalOptima was also identified to lend support via the existing agency structure and does not anticipate requesting any funding. The following letter outlines CalOptima's commitment to support the OCHCA application, based on the agency's role in Orange County and needs of members. Such commitment to participate is contingent on approval of that participation by CalOptima's Board of Directors and execution of an appropriate Memorandum of Understanding that details CalOptima's participation in helping to implement the County's project.

CalOptima currently has more than 800,000 low-income Orange County residents as members. More than 40% of members' primary language is not English, including 27% Spanish and 11%

Vietnamese. Other languages with significant representation include Korean, Farsi, Arabic and Chinese. CalOptima's population includes all ages, with approximately 11% as seniors 65+. These members receive care from a robust network of more than 1,500 contracted primary care providers and 7,600 specialists.

Therefore, given the size of CalOptima's senior population and the diverse language needs of the membership, the agency commits to supporting OCHCA's application using existing resources within its Population Health Management (PHM) and Provider Relations/Communications areas. Within PHM, CalOptima has a comprehensive plan of action for addressing needs of culturally diverse members across the continuum of care. CalOptima's PHM strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner. CalOptima regularly assesses the needs of its population through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, utilization trends and member experience surveys, and then plans programs accordingly. Utilization and medical diagnoses for members with Medi-Cal Aid Code "Aged" identify diabetes as the second-most prevalent medical condition, affecting 28.7% of this population. In Medi-Cal members 20–64 years, obesity and diabetes rank second and third, affecting 10.5% and 8.7% of members. Lastly, for Medi-Cal members age 65 and older, diabetes is identified as the second-most prevalent medical condition at 30.4% of the population (data tables enclosed).

If OCHCA is awarded, and subject to CalOptima Board of Directors approval as noted above, three CalOptima programs are available to support County efforts:

- Health Education: CalOptima's PHM department employs Registered Dieticians and Certified Diabetes Educators along with other health professionals to support CalOptima's members with diabetes and obesity management. A team of health coaches regularly intervenes in-person or telephonically, and provides culturally appropriate support for areas, such as medication adherence, exercise and diet adjustment. The goal is to decrease A1C values and improve health outcomes.
- Health Materials Validation: CalOptima understands the importance of providing members with understandable health information. The agency promotes health literacy by using appropriate resources and educational tools. In accordance with DHCS and CMS, CalOptima has a well-established process for the readability and suitability review and approval of all written member health education materials. Member health education materials are written to be age appropriate, at no higher than a sixth-grade reading level, in 12-point or 18-point font depending on visual impairment, and available in threshold languages that are culturally and linguistically appropriate for the intended audience. CalOptima intends to support OCHCA with validating content created for targeted

audiences. Validated content is proven to be effective for ongoing management of members with chronic conditions.

- Provider Training and Education: CalOptima has a long history of providing Continuing Medical Education (CME) opportunities for providers on important subjects that support better care for members. In support of the OCHCA application, CalOptima will offer CME training on health literacy in diabetes and obesity management for diverse populations. Such trainings have typically been in person but can be delivered virtually as was done in the past year during the pandemic. Depending on the community environment going forward, CalOptima will offer in-person or virtual programs to raise awareness and enhance the delivery of providers' services. Furthermore, CalOptima also publishes several provider-focused newsletters each year and can routinely include articles focused on health literacy in diabetes and obesity management.

CalOptima strongly supports OCHCA's application as it encourages COVID-19 safety and vaccination among underserved populations. Further, it will assist Orange County in achieving broader goals of health equity by improving health literacy to better reach racial and ethnic minorities, and other vulnerable populations with chronic health conditions.

If you have any questions, please do not hesitate to contact Pshyra Jones, Director Population Health Management at (657) 235-6758 or pjones@caloptima.org.

Sincerely,

Richard Sanchez
Chief Executive Officer

RS:dk

Enclosures

Cc: Dr. Clayton Chau, Health Care Agency Director and Health Officer
Dr. Emily Fonda, CalOptima Chief Medical Officer
Rachel Selleck, CalOptima Executive Director Public Affairs
Marie Jeannis, CalOptima Interim Executive Director Quality & Population Health Management
Pshyra Jones, CalOptima Director Population Health Management
Debra Kegel, CalOptima Director Strategic Development

Appendix 1: CalOptima Medi-Cal Membership Overview

Table 1: Age

Age Range	Count	Percentage
0-5	82,551	10%
6-18	225,247	29%
19-40	226,093	29%
41-64	170,808	22%
65+	83,838	11%
GRAND TOTAL	788,536	100%

Table 2: Aid Code by Medi-Cal Expansion

Aid Code	Count	Percentage
Aged	72,824	9%
Blind and Disabled	46,463	6%
Family	669,250	85%

Table 3: Top 10 Member Ethnicities

Ethnicity	Count	Percentage
Hispanic	353,944	45%
White	138,726	18%
Vietnamese	99,651	13%
No Response	79,402	10%
Other	35,529	5%
Korean	19,767	3%
Black	14,575	2%
Filipino	11,745	1%
Asian or Pacific Islander	11,360	1%
Chinese	10,316	1%

Table 4: Top 10 Member Languages

Language	Count	Percentage
English	396,713	50%
Spanish	192,267	24%
Unknown	91,615	12%
Vietnamese	71,660	9%
Korean	10,214	1%
Farsi	8,191	1%
Arabic	5,209	1%
Mandarin	2,675	0%
Tagalog	1,450	0%
Chinese	1,429	0%

Table 5: Social Determinant per ICD-10

Social Determinant	Count	Percentage
Housing & Economic	5,192	0.0%
Psychosocial	2,896	0.0%
Support & Family	2,664	0.0%
Upbringing	1,801	0.0%
Education & Literacy	756	0.0%
Employment	538	0.0%
Social Environment	514	0.0%
Occupational Risk	47	0.0%

Appendix 2: Top 5 Medical Diagnoses by Population

Table 6: Medi-Cal

Medical Diagnosis	Count	Percentage
Primary Hypertension	96,844	12.3%
Obesity	71,115	9.0%
Diabetes	59,584	7.6%
Asthma	34,718	4.4%
Acute Kidney Failure & CKD	26,066	3.3%

Table 7: Aged

Medical Diagnosis	Count	Percentage
Primary Hypertension	35,312	48.5%
Diabetes	20,908	28.7%
Acute Kidney Failure & CKD	12,738	17.5%
Heart Failure (CHF)	7,052	9.7%
Cancer	6,307	8.%

Table 8: 65 and Over Years Old

Medical Diagnosis	Count	Percentage
Primary Hypertension	42,739	51.0%
Diabetes	25,491	30.4%
Acute Kidney Failure & CKD	15,105	18.0%
Heart Failure (CHF)	8,362	10.0%
Cancer	7,719	9.2%

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

19. Consider Recommendations Related to Previously Approved and Prepaid Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to provide the organizers of community events that were cancelled or postponed due to the COVID-19 pandemic one additional year to apply CalOptima's prepayment to a future event. The event must:
    a. Occur on or before June 30, 2022;
    b. Meet the eligibility criteria described in Policy AA.1223: Participation in Community Events by External Entities; and
    c. Be approved for CalOptima's participation by CalOptima's Chief Executive Officer (CEO) or designee.
2. Make a finding that application of the prepayment to one or more future event(s) meeting these criteria are for an acceptable public purpose in support of CalOptima's community partners during the COVID-19 pandemic and are in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the CEO, with the assistance of Legal Counsel, to execute agreements as necessary for CalOptima's participation in the future event(s).

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, furthers CalOptima's mission and statutory purpose, encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves in accordance CalOptima Policy AA.1223: Participation in Community Events by External Entities

As a result of the COVID-19 pandemic, CalOptima withdrew participation in several community events, and CalOptima staff stopped attending in-person public activities, including town halls and workshops. Instead, CalOptima staff supported the community by attending virtual meetings and events. On May 7, 2020, CalOptima's Board of Directors authorized CalOptima to provide organizers of community events that were cancelled or postponed due to the COVID-19 pandemic the option of returning CalOptima's prepayments or applying CalOptima's prepayments to one or more future event(s) to occur on or before June 30, 2021. Similarly, flexibility was provided to organizers of events with financial support of $1,000 or less approved by staff in accordance with Policy AA.1223. Due to continued uncertainties related to the COVID-19 pandemic, some community event organizers who had received financial support from CalOptima have not been able to schedule events on or before June 30, 2021. Because of

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this, staff recommends that the Board authorize an additional one-year extension. Following are summaries of the previously approved events, as applicable, that CalOptima staff are requesting one additional year to apply CalOptima's prepayment to a future event.

Family Voices of California (FVCA)

The Family Voice of California event organizer reported it is unable to coordinate an event within Fiscal Year 2020–21 due to the ongoing pandemic and requested an extension to apply CalOptima's prepayment to an event in FY 2021–22. Below are details about the requesting entity and previously approved event:

- On December 5, 2019, the Board approved up to $5,000 for financial participation in the FVCA 2020 Annual Health Summit and Legislative Day that had been scheduled for on March 15–17, 2020. However, the event was cancelled and is pending a new date.

FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special health care needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with the Department of Health Care Services and the California Legislature on the Whole-Child Model program. Specifically, FVCA has reached out to Medi-Cal managed care plans, including CalOptima, to support children and families during the California Children's Services transition to the Whole-Child Model. Prior to COVID-19, CalOptima had participated in this event for three years.

Given the high-risk population served by FVCA, the uncertainly of the pandemic and the rising COVID-19 cases and deaths throughout the year, FVCA has not been able to host an in-person event in the current fiscal year. With the availability of vaccines and gradual reopening of the county and state, FVCA is confident it will be able to host an in-person Annual Health Summit and Legislative Day during FY 2021–22.

South County Senior Day: Meeting the Growing Needs of Our Aging Population

The South County Senior Day event organizer reported it is unable to coordinate an event within FY 2020–21 and requested an extension to apply CalOptima's prepayment to a future event in FY 2021–22. Below are details about the requesting entity and previously approved event:

- The Office of Senator Patricia Bates' "South Orange County Senior Day: Meeting the Growing Needs of Our Aging Population" was scheduled for April 5, 2020, with CalOptima's sponsorship at the $1,000 level, but the event was cancelled and is pending a new date.

This event is designed to support the aging population throughout South Orange County by providing educational programs to inform older adults about how to advance their concerns and learn about community resources to address their needs. Older adults have also been identified as a high-risk population with respect to COVID-19. As such, Senator Bates has not been able to host an in-person event, but expects to host the South Orange County Senior Day in FY 2021–22, when state and county

guidance is provided to support safe in-person events. Prior to COVID-19, CalOptima had participated in this event for two years.

CalOptima has a strong history of supporting the community's most vulnerable populations and collaborating with community partners, providers and key stakeholders to meet the needs of the community, and we will continue to do so consistent with federal, state and local guidance. With Governor Newsom's recent announcement of California's intended reopening on June 15, 2021, staff recommends providing FVCA and the Office of Senator Bates an additional one-year extension to apply previously prepaid participation fees to one or more future event(s) provided that such events are approved by CalOptima's CEO, meet the criteria set forth in Policy AA.1223: Participation in Community Events by External Entities, and are held on or before June 30, 2022. Further, staff requests that the Board make a finding that application of the prepayment to one or more future event(s) meeting these criteria is for an acceptable public purpose in support of CalOptima's community partners impacted by the COVID-19 pandemic and in furtherance of CalOptima's mission and statutory purpose.

In making these recommendations, staff has considered the immediate financial burden many of our community partners are experiencing, their primary focus on serving our members and others in the community, CalOptima's relationships with FVCA and the Office of Senator Bates, and their history of hosting similar events in the past. Staff understands that there may be a risk in this approach as the community organization may not host a future event or the community organization may not be in operation to host a future event. Staff is making these recommendations in support of the community organization despite the potential risks.

Fiscal Impact

There is no additional fiscal impact to the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation

Staff recommends approval of the recommended actions in response to the COVID-19 pandemic in order to continue to support community partners, such as FVCA and the Office of Senator Bates, and public activities that reflect CalOptima's mission.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated May 7, 2020, Consider Recommendations Related to Previously Approved Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Family Voices of California	1663 Mission St.	San Francisco	CA	94103

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Recommendations Related to Previously-Approved Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

Contact

Candice Gomez, Executive Director, Program Implementation, 714-246-8400

Recommended Actions

1. Authorize CalOptima to provide organizers of community events that have been cancelled or postponed due to the COVID-19 pandemic the option of either refunding CalOptima's prepayments or, alternatively, applying CalOptima's prepayments to one or more future event(s) provided that the events:
    a. Occur on or before June 30, 2021;
    b. Meet the eligibility criteria described in Policy AA.1223 ~~1123~~: Participation in Community Events by External Entities, and
    c. Are approved for CalOptima's participation by CalOptima's Chief Executive Officer (CEO).
2. Make a finding that application of prepayments to one or more future event(s) meeting these criteria are for an acceptable public purpose in support of CalOptima's community partners during the COVID-19 pandemic and are in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the CEO, with the assistance of Legal Counsel, to execute agreements as necessary for CalOptima's participation in the future events.

Rev. 5/7/20

Background/Discussion

On January 31, 2020, the Secretary of U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social and community gatherings outside of a list of "essential activities." As a result, CalOptima is not attending any-in person community events, health and resource fairs, town halls, workshops, and other public activities while the stay-at-home orders are in effect. Additionally, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19.

The CalOptima Board of Directors (Board) approved expenditures in support of CalOptima's participation in the following community events that have been cancelled or postponed due to stay-at-home orders:

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- On December 5, 2019, the Board approved up to $5,000 financial participation in the Family Choices of California 2020 Annual Health Summit and Legislative Day on March 15–17, 2020, which has now been postponed to October 4–6, 2020;
- On February 6, 2020, the Board approved up to $2,000 in financial and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival on March 22, 2020, which was cancelled;
- On March 5, 2020, the Board approved up to $2,000 in financial and staff participation at the Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event on April 5, 2020, which was cancelled;
- On March 5, 2020, the Board approved up to $2,000 in financial and staff participation at the Arts Orange County 8th Annual Dia del Nino Festival on April 18 and 19, 2020, which was cancelled; and
- On March 5, 2020, the Board approved up to $2,500 financial and staff participation at the Kid Healthy 9th Annual Cooking Up Change–Greater Orange County Event in Santa Ana on April 23, 2020, which has been postponed to a future date not yet determined.

CalOptima recognizes the unprecedented health and economic challenges our community, community partners and members are experiencing due to the COVID-19 pandemic. CalOptima has a strong history of supporting the community's most vulnerable populations and collaborating with community partners, providers and key stakeholders to meet the needs of the community and will continue to do so consistent with federal, state and local guidance. As such, staff recommends providing event organizers the option to refund previously pre-paid participation fees or apply fees to one or more future event(s) provided that such future event(s) are approved by CalOptima's CEO, meet the criteria set forth in Policy AA.1223 ~~1123~~ Participation in Community Events by External Entities, and are held on or before June 30, 2021. *Rev. 5/7/20*

In making these recommendations, staff has considered the immediate financial burden many of our community partners are experiencing, their primary focus on serving our members and others in the community, as well as CalOptima's relationships with the agencies and their history of hosting similar events in the past. Staff understands that there may be a risk in this approach as the community organization may not host a future event or the community organization may not be in operation to host a future event. Staff is making these recommendations in support of the community organizations despite the potential risks.

Fiscal Impact

There is no additional fiscal impact to the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Staff recommends approval of the recommended actions in response to the COVID-19 pandemic in order to continue to support community partners and provider activities that offer opportunities that reflect CalOptima's mission. Any refunds received would be returned to CalOptima's reserves.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated December 5, 2019, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events
3. CalOptima Board Action dated February 6, 2020, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Event
4. CalOptima Board Action dated March 5, 2020, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

Attachment 1 to May 7, 2020 Board of Directors Meeting – Agenda Item 13

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Family Voices of California	1663 Mission St.	San Francisco	CA	94103
Iranian American Community Group	6789 Quail Hill Pkwy.	Irvine	CA	92603
Access California Services	631 S Brookhurst St., Suite #107	Anaheim	CA	92804
Second Baptist Church	4300 Westminster Ave.	Santa Ana	CA	92703
The Arts Orange County	17620 Fitch, Suite #255	Irvine	CA	92614
Kid Healthy	1901 E 4th St., Suite #100	Santa Ana	CA	92705

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

18 Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community events:
    a. Up to $10,000 and staff participation at the Vietnamese Community of Southern California (VNCSC) 2019 Year of the Rat Tet Festival in Fountain Valley on January 25-26, 2020;
    b. Up to $10,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Tet Festival Year of the Rat in Costa Mesa on January 25-26, 2020; and
    c. Up to $5,000 for CalOptima's participation in the Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day on March 15-17, 2020 in Sacramento;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

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a. **Vietnamese Community of Southern California (VNCSC) 2020 Year of the Rat Tet Festival in Fountain Valley**.
Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Fountain Valley. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for six years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: One (1) 20x20 exhibitor booth in a prime location, two, three (3) 3' x 8' banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, fifteen (15) television impressions, and full ad on ten thousand (10,000) fliers distributed throughout the OC and two (2) 8'x 8' back drop on Tet Festival stage. The event organizer anticipates more than 20,000 visitors throughout the day. This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about all CalOptima's programs and services with this under-served and hard to reach population.

b. **The Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Year of the Rat Tet Festival in Costa Mesa.** Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Costa Mesa. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for thirteen years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: Five (5) minute speaking opportunity, one (1) 20x 20 exhibitor booth in a prime location, twenty (20) admission tickets, two (2) three day admission badges, one (1) banner display near the main entrance, logo link on event website for one (1) year, full page program color ad, pageant program full page ad, Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services.

c. **Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day in Sacramento.** Staff recommends the authorization of expenditures for participation in FVCA's Annual Health Summit and Legislative Day scheduled in Sacramento. FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with DHCS and the Legislature on the Whole-Child Model program. Specifically, FVCA has

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reached out to Medi-Cal managed care plans, including CalOptima, to support Orange County children and families during the California Children's Services transition to the Whole-Child Model. CalOptima has participated in this event for three years. Staff recommends CalOptima's continued support for this event with a $5,000 financial commitment for 2020, which includes the following: Verbal recognition at the Summit, CalOptima logo on the Summit materials and social media, one (1) CalOptima branded item in attendee packets and Summit attendance for two (2) representatives.

CalOptima staff has reviewed the request and it meets the consideration for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $25,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Vietnamese Community of Southern California Sponsorship Request Letter
3. Union of Vietnamese Student Associations of So. California 2020 Tet Sponsorship Package
4. Family Voices of California 2020 Annual Health Summit Sponsorship Package

/s/ Michael Schrader — *11/26/2019*

Authorized Signature — **Date**

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Attachment to the December 5, 2019 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Vietnamese Community of Southern California	P.O. Box 457	Garden Grove	CA	92842-2316
Union of Vietnamese Student Associations of Southern California	P.O. Box 2069	Westminster	CA	92684
Family Voices of California	300 J. Street	Sacramento	CA	95814

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VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
DOMESTIC NON-PROFIT CORPORATION C1479500 • EIN 33-0448822 • FOUNDED 1990
P.O. BOX 457 • GARDEN GROVE, CA 92842-2316
EMAIL: CONTACT@VNCSC.ORG • WEBSITE: WWW.VNCSC.ORG
TEL (714) 248-6191

November 6th 2019

Dear Cal Optima,

We are writing you this letter concerning a sponsorship opportunity to celebrate the upcoming Lunar New Year 2020, the Year of the Rat.

Vietnamese Community of Southern California (VNCSC) has the honor of being selected to work with County of Orange and OC Park for the celebration of the 2020 OC Tet Festival at Mile Square Regional Park in Fountain Valley, from January 24th to January 26th 2020. This 3-day special event is free admission and open to public.

This is the fourth annual Tet Festival held at Mile Square Park, which, in past years, had attracted more than eighty thousands of Southern Californians and out-of-state visitors. This is a cost-effective opportunity to promote your business, and we would like to invite you to become one of our Major Gold Sponsors as last year.

A $10,000.00 sponsorship packages will provide you:
> 20’ x 20’ booth in prime location at the Tet Festival Mile Square Park
> Three (3) 3’ x 8’ banner displays
> Twenty (20) mentions on stage
> Twenty-five (25) radio impressions
> Fifteen (15) television impressions
> Full ad size 5.5 x 8 inches (the other side will be Tet Festival announcement) on ten thousand (10,000) flyers distributed throughout Orange County prior to the event.
> Two (2) 8’ x8’back drop on Tet Festival Stage.

For almost 30 years, the VNCSC has been a strong and influential voice for Little Saigon, the largest and most established community of Vietnamese expatriates in the world. With the collaboration of other non-profit organizations, we have provided resources to help our many members of the community at large and to preserve the Vietnamese Culture and Heritage.

The name and reputation of your business will not only be remembered by our patrons who came to the event, but also be known by their relatives and friends at home, too. The exposure of your company therefore would be significant and we cordially invite you to join our activities in order to reach out one of the most vibrant Vietnamese American Communities of the world and becomes a prestigious sponsor for the Vietnamese Cultural Village in this special event.

Your contribution can definitely make a difference and we are looking forward to building a successful partnership with your company. All any additional information, please feel free to contact us at:

Vietnamese Community of Southern California (VNCSC)
P.O. BOX 457, Garden Grove, CA 92842
Phone number: (714) 248-6191, Email: vncsc1990@gmail.com

Sincerely,

Hoa Nguyen

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TẾT FESTIVAL SPONSORSHIP PROPOSAL

JANUARY 24-26, 2020
OC FAIR & EVENT CENTER

Celebrating the Year of the Rat

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DEAR PROSPECTIVE SPONSOR,

The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to our diverse audience.

The 39th Annual UVSA Tết Festival will take place between January 24 to 26, 2020 at OC Fair & Event Center — adjacent to Costa Mesa, Newport Beach, Santa Ana, and Irvine. The event attracts upwards to 50,000 guests, encompassing a multi-ethnic populace with strong Asian American presence.

The event is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- UVSA has hosted the largest Tết Festival in the nation with 38 continuous years of success
- UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California
- We are the strongest Vietnamese youth organization in the country and we represent students and young professionals in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties
- Our involvement in the community is built upon cultural awareness, education, and social and civic engagement
- We provide leadership opportunities to over 300 volunteers
- UVSA is a 501(c)(3) charitable organization and has awarded over $1,500,000 in festival proceeds to deserving non-profit organizations across Southern California

We cordially invite your team to join us this year in making UVSA Tết Festival the most spectacular yet! We look forward to building a partnership with you as we welcome the Year of the Rat with prosperity and success for all. Thank you for your consideration.

Sincerely,

Nguyen D. Nguyen
President
president@uvsa.org

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FESTIVAL SUMMARY

EVENT
39th Annual UVSA Tết Festival

DESCRIPTION
Tết is a celebration of the Lunar New Year, the most observed holiday for Vietnamese people

OBJECTIVES
1. To celebrate the new lunar year
2. To preserve and promote Vietnamese culture & traditions with the surrounding community
3. To provide opportunities for local businesses to promote their products and services
4. To raise funds to support educational and cultural programs in the community
5. To bring Vietnamese youths together and provide them with opportunities for leadership development and community service

DATES
Friday, January 24, 2020; 4PM - 10PM
Saturday, January 25, 2020; 11AM - 10PM
Sunday, January 26, 2020; 11AM - 9PM

LOCATION
OC Fair & Event Center
88 Fair Dr., Costa Mesa, CA 92626

ATTENDANCE
50,000+ guests

Lion dancers performing at the Saturday Opening Ceremony

ATTRACTIONS
Carnival games and rides
Three stages, each offering a variety of programming for all ages
Vietnamese cultural village with over 30,000 sq feet of exhibits and structures
Exhibit hall with over 100 unique vendors

PROGRAMS

Miss Vietnam Pageant	Opening Ceremony	Children's Contests
Pho Eating Contests	Talent Show	Dance Competition
Live Music & Karaoke	Youth Night	Grand Concert
Gaming Tournaments	Cultural Performances	Influencer Meet & Greet

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HOSTING ORGANIZATION

ABOUT The Union of Vietnamese Student Associations of Southern California (UVSA) is a 501(c)(3) non-profit, non-partisan, community-based organization founded in 1982 consisting of students, alumni, young professionals, and community leaders. Our mission is to bring together Vietnamese American students and young professionals across Southern California to build unity, to serve the community, and to advocate for social justice issues that affect our community domestically and in Vietnam.

GRANTS Each year, half of net profits from the event are allocated towards the Tết Community Assistance Fund. Over the past 15 years, UVSA has awarded over $1.5 million to help Southern California non-profit organizations initiate community enrichment programs.

MEMBERS UVSA was founded on volunteerism and continues to be a 100% volunteer-based organization. With over 50 year-round staff, 300 project staff, and 500 day-of volunteers, UVSA strives to equip each volunteer with skillsets that will help them excel in their professional careers. Additionally, UVSA partners with local, self-governing Vietnamese student associations from the following universities:

- Chapman
- Cal Poly Pomona
- CSU Fullerton
- CSU Long Beach
- CSU Northridge
- San Diego State
- UC Irvine
- UC Riverside
- UC Santa Barbara
- UC San Diego
- University of Southern California

DEMOGRAPHICS & STATISTICS

According to the 2018 U.S. Census, 1,548,449 people identify as Vietnamese, ranking them fourth among the Asian American groups; 447,032 (40%) of them live in California. The largest Vietnamese population outside of Vietnam is found in Southern California—totaling over 300,000 members from Los Angeles, Orange, and San Diego counties. Vietnamese American businesses continue to grow in areas such as Garden Grove and Westminster while rapidly extending lucrative development to surrounding cities.

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KEY BENEFITS

The success of this event depends on the generosity of sponsors. In return, UVSA aims to provide sponsor with the following benefits:

- Brand awareness and brand loyalty from current and prospective buyers
- High-level media exposure from local television stations, radio stations, magazines, newspapers, and advertisements
- Large-scale onsite product promotion and face-to-face customer interaction
- Positive public outreach and market response
- Recognition as an industry leader above competitors

Toyota showcases their latest vehicles in a custom 30' x 40' booth

The Miss Vietnam of Southern California Royal Court pose for Lexor's custom 20' x 10' booth

The Miss Vietnam of Southern California Royal Court pose for Sunpower's 20' x 20' booth

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SPONSOR PACKAGES

We offer the following sample packages which include standard benefits. However, we prefer to create for you a custom package designed to best connect your business to our audience. We hope that you take this opportunity to sponsor the event as a means to promote brand loyalty from a very accomplished community.

	SPONSOR BENEFITS	MEDIA OR IN-KIND TRADE (varies with value)	BRONZE $3,500	SILVER $6,000	GOLD $12,000	DIAMOND $20,000	TITLE $35,500
PRE-EVENT	Logo and link on event website for 1 year	✓	✓	✓	✓	✓	✓
	Social media post				✓	✓	✓
	Logo on event ad in Vietnamese newspapers					✓	✓
	Logo on all promotional materials						✓
	Logo on online admission tickets						✓
	Logo on event billboard in Garden Grove						✓
ON-SITE	Booth in prime location	10' x 10'	10' x 10'	10' x 20'	20' x 20'	20' x 30'	20' x 40'
	Admission tickets	30	10	20	40	90	150
	3-day admission badges	1	1	2	4	8	10
	3-day parking hang tags	1	1	2	4	8	10
	Banner display near main entrance	1	1	1	1	1	1
	Banner display near exit				1	6	1
	Banner display near main stage				1	2	4
	Graphic ad on main stage				3 runs / day	5 runs / day	5 runs / day
	Color ad on in event program book				half page	full page	back cover
	Logo on back of 500 volunteer t-shirts					✓	✓
	Logo on event directory					✓	✓
	30-second video ad on Main Stage						2 runs / day
	Speech at opening ceremony						5 minutes
	Speech at pageant with check presentation						5 minutes
	Sponsor mentions on PA system looped inside event entrance area						✓
	Logo on back of all admission tickets						✓

A LA CARTE BENEFITS

Admission Tickets — $6 ea
Admission Badges — $30 ea
Parking Hangtags (3-day) — $30 ea
Logo link on event website for 1 year — $500
Banner ad link on event website for 1 year — $750
Logo on back of 500 volunteer t-shirts — $500
Logo on event ad in newspapers — $1,000
Social media post — $250
Logo display on ticket booth windows — $400
Banner display (stage, gates, food court) — $500

On-site event activation with booth:
- 10' x 10' — $3,000
- 10' x 20' — $5,000
- 20' x 20' — $8,000
- 20' x 30' — $12,000
- 20' x 40' — $16,000

Program Book Ads (30,000 prints)
- Half-page color — $1,000
- Full page color — $1,500

Speaking opportunities — $1,000 (5 min)

Main Stage LED Screen Ads
- Graphic — $100 (1 run / day)
- 30-second video — $500 (1 run / day)

Presenting Sponsor for Programs:
- Pho Eating Contest — $1,500
- Children's Pageant — $1,500
- Talent Show — $1,500
- Youth Night — $3,000
- Grand Concert — $3,000

Pageant program full page ad — $1,000

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PLEDGE FORM

COMPANY NAME: _____

CONTACT NAME: _____ TITLE: _____

PHONE: ( ) _____ EMAIL: _____

SPONSORSHIP PACKAGE

- ☐ BRONZE ($3,500)
- ☐ SILVER ($6,000)
- ☐ GOLD ($12,000)
- ☐ DIAMOND ($20,000)
- ☐ TITLE ($35,500)
- ☐ MEDIA TRADE valued at: $ _____
- ☐ IN-KIND TRADE valued at: $ _____
- ☐ CUSTOM PACKAGE: $ _____
- ☐ DONATION ONLY: $ _____

PLEASE DESCRIBE ANY REQUESTS FOR YOUR SPONSORSHIP: _____

PLEASE DESCRIBE YOUR SERVICES: _____

_____ _____

SIGNATURE DATE

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UNION OF VIETNAMESE STUDENT ASSOCIATIONS OF SOUTHERN CALIFORNIA

"DEVELOPING THE NEXT GENERATION OF LEADERS"

CONTACT US

Tel: (714) 388-6711
Email: tet.sponsorship@uvsa.org

MAIL
PO BOX 2069
WESTMINSTER, CA 92684

WEBSITE
WWW.UVSA.ORG | WWW.TETFESTIVAL.ORG

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FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care

Alpha Resource Center of Santa Barbara
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
(805) 683-2145
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Ave.
Suite 6050, Unit 35
Alhambra, CA 91803
(626) 300-9171
info@elafrc.org

Family Resource Navigators
291 Estudillo Ave
San Leandro, CA 94577
(510) 547-7322
eileenc@frnoakland.org

Support for Families of Children with Disabilities
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494
info@supportforfamilies.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494

info@familyvoicesofca.org
www.familyvoicesofca.org

October 22, 2019

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima

Re: Sponsorship Request for Family Voices of CA 2020 Health Summit

Dear Tiffany:

Family Voices of California (FVCA) provides families of children and youth with special health care needs (CYSHCN) with information, tools, and support to advocate for better access to high quality care. We build partnerships, inform stakeholders, and foster parent engagement to give families a voice in healthcare policy making.

We would like to request sponsorship from CalOPtima for our 2020 Annual Health Summit and Legislative Day, which will be held on March 15-17, 2020 in Sacramento so that we may continue to advance these efforts. CalOPtima's sponsorship would specifically support family members from Orange County who are in the Whole Child Model program to attend the Summit. The funds will cover their travel, lodging, meals and a stipend for the 2 ½ days of meetings.

Advocates, health care providers and professionals, government representatives, and legislators and staff will join parents and caregivers for updates on health policy issues facing CYSHCN. Speakers will provide policy and program updates, and families will share perspectives on the impact of policies on their lives. The Summit will be followed by legislative meetings at the State Capitol, where families will educate lawmakers about the issues they face and put a personal face on the impact of legislation and budget decisions.

With your sponsorship we can make our 2020 Summit a great success by:

- Educating and informing parents and decision makers about critical issues facing CYSHCN.
- Building collaboration among families, legislators, regulators, providers, and community based organizations to increase parent involvement at all levels of community and government health policy making.
- Engaging parents in policymaking through legislative meetings.

Nearly 100% of those attending our 2019 Summit agreed that the support, information, and resources they received helped them feel more confident about getting their child the health care and services they need; and as a result they took action during Legislative Day and beyond. With your support FVCA can continue our work to advance public policies and system improvements that will help families of CYSHCN access the care they need.

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Please see the attached menu of sponsorship activities, and don't hesitate to contact me for more information at pipmarks@familyvoicesofca.org or 415-282-7494 ext. 123.

Thank you for your consideration of this request!

Sincerely,

Pip Marks
Project Director

FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please return your completed form to Pip Marks at pipmarks@familyvoicesofca.org or 1663 Mission Street, Suite 700, San Francisco, CA 94103

☐ Leadership – $10,000

A speaking role at the Summit
Verbal recognition at the Summit
Prominently placed logo on Summit materials
Inclusion of 1 item in attendee packets
Inclusion in social media marketing
Summit attendance for 3 representatives

☐ Spirit – $5,000

Verbal recognition at the Summit
Logo on Summit materials
Inclusion in social media marketing
Inclusion of 1 item in attendee packets
Summit attendance for 2 representatives

☐ Partner – $2,500

Verbal recognition at the Summit
Logo on Summit materials
Summit attendance for 1 representative

☐ Collaboration – $1,500

Verbal recognition at the Summit
Listing in Summit materials
Summit attendance for 1 representative

☐ Hope – $800 x _____ = $ _____ **(**Sponsor a family member to attend the Summit)

Listing in Summit materials

Sponsor a parent/caregiver of a child with special health care needs to attend the Summit. Each family sponsorship provides travel, lodging, and childcare.

☐ Other – Donation

Amount:

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FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please make checks payable to:
Support for Families of Children with Disabilities
and reference/memo Family Voices of California

Please return your completed form and send to:

Pip Marks at pipmarks@familyvoicesofca.org
or
1663 Mission Street, Suite 700, San Francisco, CA 94103

Name: _____

Organization/Company: _____

Address: _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Thank you for your support of families of children and youth with special health care needs!

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Event

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize expenditure for CalOptima's participation in the following community event:
    a. Up to $2,000 and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival in Irvine on March 22, 2020;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended event will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

a. **Iranian American Community Group's 7th Annual Persian Nowruz Festival.** Staff recommends the authorization of expenditures for participation in the Iranian American Community Group's 7th Annual Persian Nowruz Festival. This is an educational event celebrating the Persian New Year that highlights the culture and traditions of the Persian community. The event will include cultural performances, traditional foods and resource

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tables. This event provides an opportunity to share information about CalOptima's programs and services with our members who speak Farsi, which is one of CalOptima's threshold languages. A $2,000 financial commitment for the Iranian American Community Group's 7th Annual Nowruz Festival includes: CalOptima's name and logo on recognition banner, event program and announcement on main stage, one (1) resource booth and invitation to VIP tent at the event. The event draws nearly 4,500 annually from the Persian community, Persian organizations and their members and Iranian-American community leaders. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Farsi and share information about CalOptima's programs and services.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $2,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support a community activity that offers an opportunity that is in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

1. Entities Covered by this Recommended Board Action
2. Nowruz 2020 Sponsorship Package

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Iranian American Community Group of Orange County	6789 Quail Hill Pkwy, Ste. 626	Irvine	CA	92603

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Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Dear Nowruz Sponsor:

On behalf of Nowruz 2020 Iranian American Community Group (IACG) Festival Committee, I am pleased to invite you to join our circle of sponsors to support this exciting cultural event.

On Sunday, **March 22, 2020, from 1-6 pm,** the Persian community will celebrate the **7th Annual Persian Nowruz Festival (Eid)** at the Rose Garden at Bill Barber Community Park (next to Irvine's city hall), in Irvine, California.

For thousands of years Iranians have celebrated Nowruz as the beginning of the year. The colorful celebration of Nowruz marks the beginning of spring and Persian New Year, which is a time to begin a new life, and the first day of spring.

Since 2014, volunteers from several supporting non-profit organizations gather annually to create an extraordinary event to showcase the rich Persian culture. This fun event includes free entrance to the festival, music, dance, children's activities, Persian cuisine, and much more. The number of participants has grown steadily over the years to nearly 4,500 annually. This year we expect that number to be even greater.

Sponsorship of Nowruz provides your business with a unique opportunity to reach thousands of Iranian-Americans living in Southern California. While engaging and inspiring, your participation will allow you to extend your loyalty to Persian culture among thousands of visitors to the festival.

The enclosed materials provide information on the levels of sponsorship and the benefits associated with each level. Please take this opportunity to become involved with the community while promoting Persian culture and your business to thousands of attendees.

We look forward to recognizing you as one of our major sponsors at Nowruz 2020. Please e-mail us at iacgroupoc@gmail.com with any questions you may have.

Best Regards,

Kamran Taghdiri, PhD, IAC Nowruz Executive Director & CFO
Nowruz Festival Committee

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsorship Levels

IAC Group is a 501 (c) (3) organization (**Tax ID #: 47-5363120**)

Your sponsorship is a valuable component of Nowruz celebration festival. Your support will help us to exhibit and represent diverse collection of traditional events and lively programs. It will also encourage children to learn about their rich heritage by participating in this cultural event.

PLATINUM Sponsor ($ 2,000 +)

- Name and logo display on a recognized banner at a recognized section at the event
- Name and logo display on recognized section of the program hand out to participants
- Announcement on main stage as platinum sponsor
- A table at the event for distributing company's information (no sales transactions)
- Invitation to VIP tent of the event

GOLD Sponsor ($ 1,000 +)

- Name display on banner at a recognized section at the event
- Name on gold sponsors section of the program hand out to participants
- A shared table with other gold sponsors to hand out company's information (no sales transactions)

SILVER Sponsor ($ 500 +)

- Name display on banner at the event
- Name on silver sponsors section of the program hand out to participants

Friends of Nowruz ($ 100 +)

- Name on Friends of Nowruz section of program hand out to participants

Iranian American Community Group

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsor Information

First Name: _____ Last Name: _____

Company/Organization: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____

Email: _____

Sponsorship Levels: (Please check options)

Description	Amount	Select
Platinum Sponsor	$ 2,000+	
Gold Sponsor	$ 1,000+	
Silver Sponsor	$ 500+	
Nowruz Friends	$ 100+	

Check: Check #_____ Bank Name_____

Sponsor Signature: ……. **Date:** ……...

Please Mail to: **Nowruz 2020 Celebration**
IAC Group
6789 Quail Hill Pkwy, Suite 626
Irvine, CA 92603

(Tax ID #: 47-5363120)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize expenditure for CalOptima's participation in the following community events:
    a. Up to $2,000 and staff participation at Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event in Santa Ana on April 5, 2020;
    b. Up to $2,000 and staff participation at the Arts Orange County's 8th Annual Dia del Nino Festival on Saturday and Sunday, April 18 and 19, 2020;
    c. Up to $2,500 and staff participation at Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event in Santa Ana on April 23, 2020; and
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

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a. **Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event.** Staff recommends the authorization of expenditures for participation in Access California Services' Family Wellness Event. This is an educational event with a focus on mental health to address behavioral health challenges, stigma, cultural barriers, acculturation, and access to health/mental health services. CalOptima will have an opportunity to highlight behavioral health services available to our members. This event also provides an opportunity for CalOptima to interact with our members who speak the threshold languages of Arabic and Farsi and other attendees about our behavioral health services. A $2,000 financial commitment for Access California Services' 3rd Annual Peace of Mind Family Wellness Event includes: Opportunity for CalOptima leadership to share information about CalOptima's behavioral health services, CalOptima's name and logo on all marketing materials, one (1) resource booth and verbal recognition on the day of the event. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Arabic and Farsi and share information about CalOptima's programs and services.

b. **Arts Orange County's 8th Annual Dia del Nino Festival.** Staff recommends the authorization of expenditures for participation in the Arts Orange County's Annual Dia del Nino Festival. This is an educational event and resource fair with 30 interactive arts workshops and performances by professional guest artists and community artists to celebrate the richness and cultural heritage of Orange County's Latino community. This event attracts over 10,000 attendees and provides CalOptima an opportunity to share information about our programs and services with our Latino membership, which comprises approximately 45% of our total membership. Employee time will be used to participate in this event. A $2,000 financial commitment for the Arts Orange County's 8th Annual Dia del Nino Festival includes: One (1) resource booth, CalOptima's name and logo on event promotional materials and social media and invitation for CalOptima leadership to be recognized at the event.

c. **Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event.** Staff recommends the authorization of expenditures for participation in Kid Healthy's Cooking Up Change Greater Orange County Event. This event is a collaboration with school districts throughout Orange County to empower students to create and advocate for healthy school meals. Students from low-income schools are provided a platform to transform the school lunch menu using cost guidelines and high nutrition standards and to develop their leadership skills. Twelve high school teams from the cities of Anaheim, Santa Ana, Fullerton, Buena Park, Garden Grove, La Habra and Whittier compete in this event. This event provides CalOptima an opportunity to share information about our programs and services with our members. A $2,500 financial commitment for Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event includes: One (1) resource booth, CalOptima's name and logo on event signage, social media and video, complimentary event tickets for six, and invitation for VIP reception for two. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. This event also provides CalOptima an opportunity to strengthen our relationship with the school districts serving our members.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact
Funding for the recommended action of up to $6,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community activities that offer opportunities that are in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. Access California Peace of Mind Sponsorship Package
3. Arts Orange County Dia del Nino Festival Sponsorship Package
4. Kid Healthy Cooking Up Change Sponsorship Package

/s/ Michael Schrader *02/26/2020*
Authorized Signature **ate**

Attachment 1 to the March 5, 2020 Board of Directors Meeting – Agenda Item 22

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Access California Services	631 S. Brookhurst St., Suite 107	Anaheim	CA	92804
Arts Orange County	17620 Fitch Ave., Suite 255	Irvine	CA	92614
Kid Healthy	1725 S. Douglass Rd.	Anaheim	CA	92806

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Arts Orange County's Día del Niño 2020

BRIEF DESCRIPTION OF PROJECT:

"Día del Niño," a free admission two-day festival, April 18-19, 2020, features daily 30 interactive arts workshops and performances by professional guest artists and community artists. It celebrates the artistic richness and cultural heritage of Orange County's multi-faceted Latino community through engaging arts experiences, connects residents to local arts organizations, provides them with access to new artistic disciplines, and fosters creativity and exploration among children and families of all backgrounds and heritages. Expected attendance: 10,000.

REQUEST AMOUNT: $10,000

TOTAL PROJECT BUDGET: $95,000

PRIMARY POPULATION: FAMILIES

NUMBER OF PEOPLE SERVED: 10,000

ORGANIZATION'S MISSION & VISION:

Arts Orange County's mission is to be the leader in building appreciation of, participation in, and support for the arts and arts education in Orange County, California. It aspires to play a key role in advancing the success of Orange County's creative community through excellence in its programs and services, advocacy


Fern Street Circus at the 2018 and 2019 Dia del Ninos will again conduct workshops at the 2020 event.

efforts that result in increased private and public investment in arts and culture, community cultural planning, the expansion of art in public places, the full restoration of standards -based arts instruction in the public schools, equitable access to arts experiences countywide, and a thriving business community that embraces creativity and innovation. Governed by a diverse Board of Directors comprised of artists, leaders of arts organizations, the County Superintendent of Schools, leaders in higher education and business, and arts patrons, ArtsOC serves over 600 arts & culture organizations countywide. ArtsOC offers high quality core programs and services typical of local arts agencies that are supplemented with consulting services that are quite unusual for an organization of its type and serve an important local need.

This painting workshop was popular at the 2018 and 2019 Dia del Ninos and is being offered again at this year's event.

WHAT RESULTS/IMPACT HAS YOUR ORGANIZATION ACHIEVED IN THE PAST THREE YEARS TOWARD MISSION?

ArtsOC has played a leading role in advocacy efforts at the local, state, and national level that have resulted in significant gains in the restoration of public funding for arts & culture that was decimated during the recession. This has brought tens of thousands of dollars in new and increased funding for arts organizations and for public schools in Orange County. With greater focus upon creative placemaking as a tool to help invigorate city life, ArtsOC has played a leading role in the installation of art in public places in Santa Ana, Costa Mesa, and Newport Beach as consultants and managers on contract with local government and nonprofit organizations. Additionally, ArtsOC has been at the forefront of programmatic innovation through being selected for pilot programs utilizing the arts for therapeutic purposes (our VOICES: Veterans Storytelling

Crowds of all ages loved the performances by Relampago del Cielo at the 2018 and 2019 Dia del Nino.

Project), re-entry for offenders (Arts in OC Jail Project), and providing entry-level arts experiences for the underserved, as evidenced in the "Dia del Nino" Festival for which we are seeking Pacific Life Foundation support.

WHAT CHALLENGES HAS YOUR ORG FACED OVER PAST 3 YEARS AND HOW HAVE YOU MET THEM?

Nonprofit local arts agencies, like Arts Orange County, are at a competitive disadvantage in attracting support within the philanthropic marketplace--largely because the work they do is behind the scenes and in support of other arts organizations that have the natural attraction of constituencies through producing and presenting work. Additionally, a countywide organization like ours attempting to serve 34 cities, with their own identities and indigenous arts communities, has its work cut out for it to be effective. Probably the most effective tool in addressing these particular challenges has been ArtsOC's growing role as a cultural planner on contract with local municipalities. The planning process has created a by-product of building image and awareness of ArtsOC's mission and brand. Cultural planning work for Irvine, Mission Viejo, Newport

Dance of the Jaguar performing at the 2019 Dia del Nino will return for 2020.

Beach and Costa Mesa has raised ArtsOC's profile considerably and connected it to new sources of support. Additional cities learn of ArtsOC's planning services directly or through their colleagues, and the demand shows signs of continuing to grow.

WHAT IS THE CHALLENGE OR OPPORTUNITY THIS PROJECT ADDRESSES?

The Latino community constitutes more than one-third of Orange County's overall population, there is limited representation of Latino arts and culture in the offerings of established organizations countywide, and a community "Dia del Nino" festival offered by another community arts organization was discontinued after a one-time presentation.

These led ArtsOC in 2012 to initiate its "Dia del Nino" festival, which will enter its ninth year in 2020. It was important to us from the beginning that the festival be authentic, be curated and presented in partnership with a local Latino community arts organization, that the event would go well beyond offering simply a passive


Emily, a well-known Tejano singer will bring her sensational voice and smile to the 2020 Dia del Nino.

experience to attendees, and that each person who attends is directly engaged to participate and explore their own creativity in a variety of ways.

ANTICIPATED IMPACT OF PROJECT

"Dia del Nino" is designed to inspire lifelong learning and participation in the arts among 10,000 children and adults, to broaden the community's understanding of Latin-American arts & culture, to showcase talented student and amateur artists, to provide employment to outstanding professional teaching artists and world-class performing artists, and to introduce families to important local arts organizations, classes and agencies available throughout the county to continue their cultural exploration, enjoyment and artistic development.

KEY ELEMENTS OF THE PROJECT

To achieve the stated results, we will collaborate with a respected Latino community arts organization (Media Arts Santa Ana) together with which we will employ a curatorial approach that embraces presenting major national and regional Latin-American performers, including Grammy Award-winning recording

Claudia de la Cruz is a nationally-known flamenco artist who will perform and teach at the festival.

artists, and the best local community artists and student talent from schools throughout Orange County.

All festival communications will be bilingual (English and Spanish) and the festival location will be fully accessible to those with disabilities. We will promote the event widely through the OC Department of Education, OC Public Libraries, shops and restaurants in Latino neighborhoods, a schedule of PSAs on KOCE-TV, the Los Angeles/Orange County flagship PBS station, and our media partner La Ranchera 96.7 FM, a popular Spanish-language Southern California radio station that reaches 420,000 listeners.

Throughout the days of the festival, there will be continuous performances on stage by such performing artists as the Latin Grammy Award-winning “kindie” band Lucky Diaz and the Family Jam Band (Día del Niño 2018), Grammy Award-nominated all-string Latin-American ensemble Trio Ellas (Día del Niño 2016-19), Latin Grammy nominee Ciro Hurtado, original and traditional Andean guitar music (Día del Niño 2014), Mariachi Divas, multiple Grammy Award-winning all-female mariachi band (Día del Niño 2016), Relámpago del Cielo Grupo Folklorico, a 40

Student performers are part of the offerings at Dia del Nino.

year old professional traditional Mexican performing arts organization (Día del Niño 2012, 2018, 2019), Pacific Symphony String Quartet from Orange County's major orchestra (Día del Niño 2017), Moona Luna (Día del Niño 2018), Tejano singer Emily (Día del Niño 2018-19), Claudia de la Cruz Flamenco Dancers (Día del Niño 2018-19), and Fern Street Circus (Día del Niño 2018-19), among others.

Between performances, bi-lingual (English and Spanish) emcees will offer standup comedy, recite poetry, promote participating organizations and recognize the sponsors of the event—in 2018, Dyana Ortelli, the voice of Tia Victoria in the Academy Award winning Disney/Pixar film "Coco," emceed.

Ongoing workshops will offer instruction in a wide range of arts and crafts, including include flamenco, modern and hip-hop dance, clay flute making, papier-maché, drumming, beading, sketchbook making, poetry, video, theatre, painting, mosaics, puppetry, drum making, and circle painting.

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Workshops are offered in a wide variety of crafts: clay, fiber, and book-making are popular.

SUSTAINABILITY OF PROJECT

ArtsOC measures the event's success through the use of a face-to-face exit survey conducted in English and Spanish in order to determine if the festival experience would prompt attendees to pursue additional hands-on arts engagement throughout the year. ArtsOC will encourage featured local "Dia del Nino" festival workshop artists and performing artists to utilize their appearance in the festival as an opportunity to showcase their work to attendees as a means of encouraging continued participation--whether through ongoing classes they offer in the community or through private instruction. Exhibiting organizations at the festival also provide information about instructional programs they offer as well as opportunities for practitioners to hone their skills. Social media is used to continue the engagement and conversation with participants, leading up to the announcement of the following year's festival.

With respect to sustainable funding for "Dia del Nino," the festival has received seven consecutive years of funding from the National Endowment for the Arts


Dia del Nino is a participatory experience for ALL ages!

and five consecutive years of funding from the Wells Fargo Foundation to support this program. While those are not guaranteed multi-year grants, our track record of success with those sources makes future grants more likely. Those grants are not alone sufficient to cover all of the costs, so additional funding from other sources is necessary and varies from year to year. But ArtsOC has thus far been successful in securing sufficient funds each year to sustain what has come to be regarded widely in the community as a worthwhile annual program.

CURRENT FUNDING FOR THE PROJECT:

National Endowment for the Arts - $25,000
California Arts Council - $15,000
The Crean Foundation - $15,000
The Lyons Share Foundation - $10,000
Pacific Life Foundation - $10,000
Wells Fargo Foundation - $5,000
OC Fair & Event Center - $5,000

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NATIONAL

Join the Movement: Students Transforming the Future of School Food
Be a Lunch Hero: sponsor Cooking up Change® 2020 at the level indicated below (check one)

☐ **Super Hero: $20,000 or above:**
- Company Logo on ALL event print materials
- Recognition in social media campaign weekly
- Complimentary event tickets for 20
- Invitation for 10 to VIP Reception
- Company logo and hot link on event website
- Company representative to welcome attendees
- Company representative to present student awards
- Company representative interviewed in event video
- Company logo on chef jackets
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Power Partner: $15,000 or above:**
- Company logo on event print materials
- Company logo on event signage & video
- Recognition in social media campaign
- Complimentary event tickets for 15
- Invitation to VIP Reception for 8
- Company logo and hot link on event website
- Company representative to assist with awards presentation
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Awesome Ally: $10,000 or above**
- Company logo on event print materials
- Company logo on signage, social media campaign & video
- Complimentary event tickets for 10
- Invitation to VIP Reception for 6
- Company logo on website, photo booth props
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Super Side-Kick: $5,000 or above:**
- Company Logo on event print materials
- Recognition on event signage
- Recognition in social media & video
- Complimentary event tickets for 8
- Invitation to VIP Reception for 4

☐ **Marvelous Mate: $2,500 or above:**
- Complimentary event tickets for 6
- Invitation to VIP Reception for 2
- Recognition in social media & video
- Recognition in event signage

☐ **Amazing Associate: $1,000 or above:**
- Recognition in event signage
- Complimentary event tickets for 4
- Recognition in social media & video

☐ **Sensational Supporter: $300 or above:**
(non- profits & individuals only)
- Complimentary event tickets for 2
- Recognition in event signage

☐ **Friendly Force:**
Please accept my donation of $_____

Thank you for your support of Kid Healthy, please return this form:

Ma to:
K d Hea thy c/o OneOC
1901 E. Fourth Street, Su te 100 Santa Ana, CA 92705
nda@myk dhea thy.org

For Further nformat on Contact:
L nda Luna-Franks, Exec. D r.
949.874.7701
linda@mykidhealthy.org

kid HEALTHY

Charge my (circle one): Visa MasterCard American Express Check (Enclosed)

Amount $_____(Please make checks payable to Kid Healthy)

Name on Card:_____CardNo._____

Signature:_____Expiration Date:_____SecurityCode:_____

Company/Name:_____

Address:_____

Contact:_____Phone: _____Email:_____

Kid Healthy is a fiscally sponsored project of OneOC, a 501C3 not for profit Organization. All gifts are tax deductible as allowed by law.

Tax ID# 95-2021700

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
20. Consider Approving CalOptima Positions on Proposed Legislation

Contacts
Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions
1. Approve CalOptima's formal positions on proposed legislation, as follows:
    a. AB 523 (Nazarian): SUPPORT
    b. SB 316 (Eggman): SUPPORT
2. Authorize the Chief Executive Officer, or designee, to implement legislative education and advocacy efforts in alignment with the approved CalOptima positions.

Background
As part of its Government Affairs program, CalOptima staff track and analyze state and federal legislation that may impact CalOptima and its members, providers and other stakeholders. Staff also engage with federal and state trade associations, federal and state advocates, and elected officials at all levels of government to educate them on how proposed legislation and regulatory guidance may impact CalOptima. Subject to Board direction, these efforts may include advocating for or against legislation in the United States Congress and California State Legislature in alignment with CalOptima's 2020–22 Strategic Plan, 2021–22 Legislative Platform, and/or other agency goals and policy priorities.

On April 1, 2021, the Board adopted CalOptima's 2021–22 Legislative Priorities and Legislative Platform to help guide legislative advocacy efforts by staff.

Summary
Staff recommends approval of CalOptima's formal positions on proposed legislation, as follows:

Bill Number (Author)	Bill Title	Summary/Impact	Legislative Priority Area	Recommended Position
AB 523 (Nazarian)	PACE Flexibilities	Would permanently extend most flexibilities granted to PACE organizations during the COVID-19 public health emergency. This includes flexibilities relating to telehealth services, verbal agreements followed with in-person signatures, Adult Day Health Center home-based services, and discharge planning.	Older Adult Services	**SUPPORT**

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SB 316 (Eggman)	Same-Day Billing for Federally Qualified Health Centers (FQHCs)	Would allow an FQHC to be reimbursed for two separate visits for physical health services and mental or dental health services on the same day. This would allow members to receive necessary care on the same day instead of waiting 24 hours.	Medi-Cal Managed Care: Operations and Administration	**SUPPORT**

A detailed summary and impact analysis of the proposed legislation, as well as the current text of the proposed legislation, are included as attachments.

Staff also recommends authorization for the Chief Executive Officer, or designee, to implement legislative education and advocacy efforts in alignment with the approved positions. These efforts may include executing letters expressing CalOptima's positions to legislators or other government officials, meeting with such officials or their staff, and/or directing CalOptima's contracted lobbyists to advocate the approved positions on behalf of CalOptima.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Educating stakeholders and proactive engagement with trade associations, advocates and elected officials is critical to influencing policy decisions that are likely to impact CalOptima. Based on discussions with CalOptima's contracted lobbyists and trade associations, staff recommends that CalOptima takes formal positions on the referenced proposed legislation.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Legislative Analysis: AB 523
2. Current Text of AB 523 (as of May 3, 2021)
3. Legislative Analysis: SB 316
4. Current Text of SB 316 (as of February 4, 2021)

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Legislative Analysis: Assembly Bill 523

PACE Flexibilities

Background

The Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. CalOptima PACE serves nearly 400 participants, all of whom have complex chronic medical conditions in addition to functional and/or cognitive impairments.

COVID-19 created an unprecedented challenge for CalOptima PACE and its members. The high-touch program for frail, older adults immediately transitioned to a home-based setting, primarily relying on telephonic interactions to address medical needs.

In addition, the Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to authorize temporary regulatory flexibilities (Table 1.), leveraging existing Home- and Community-Based Services to reduce and avoid SNF stays and transition Medi-Cal beneficiaries into a PACE center when possible. These flexibilities enabled PACE Organizations (POs) statewide to continue to care for older adults throughout the pandemic, resulting in fewer COVID-19 cases and deaths in comparison with SNFs.

Overview

Assembly Bill (AB) 523, authored by Assemblyman Adrin Nazarian, seeks to permanently extend most PACE flexibilities granted during the public health emergency, as outlined in Table 1.

Table 1. Temporary Flexibilities for PACE Organizations

Temporary Flexibilities
Suspension of requirement for in-person marketing exams for PACE staff
Flexibility to deliver medically necessary services via in-person visit or telehealth, as deemed appropriate by the PO
Flexibility to provide PACE Center and Adult Day Health Center (ADHC) services in settings outside of the licensed ADHC, including in the home
Flexibility to waive involuntary disenrollment for participants who have temporarily moved out of the PACE service area due to COVID-19 concerns
Flexibility to temporarily place participants in hospitals/ facilities outside of the PACE service area.
Flexibility to adjust the in-person enrollment requirements in the PACE program, under the condition that the enrollment activities are completed via non-public-facing, two-way real-time audio or video using an acceptable application
Flexibility to obtain a verbal signature or verbal concurrence from the participant and/or their designated representative in lieu of signature

Impact

The current temporary flexibilities enabled CalOptima's PACE Center to operate a *PACE Without Walls* program, providing person-centered care virtually and at home. In 2020, this resulted in:

- 80 new participants enrolled in CalOptima PACE by providing verbal agreements
- 1,400 wellness kits delivered to participants' homes
- 13,000 telehealth visits
- 30,500 home health and home care hours provided
- 3,000 meals delivered to participants' homes
- 35,600 wellness calls made by PACE staff

If made permanent, these flexibilities would continue to benefit CalOptima PACE members beyond the termination of the COVID-19 public health emergency.

Support/Opposition

AB 523 is sponsored by CalPACE, a state trade association that advocates on behalf of PACE programs. Of note, CalOptima is a paid member of CalPACE with an active seat on its Board of Directors. Additional organizations in support of AB 523 include:

- Alzheimer's Greater Los Angeles
- Alzheimer's Orange County
- Alzheimer's San Diego
- California Alliance for Retired Americans
- California Association of Area Agencies on Aging
- California Association of Public Authorities for IHSS
- California Commission on Aging
- California Hospital Association
- California Retired Teachers Association
- Center for Elders Independence
- LeadingAge California
- On Lok
- WelbeHealth

There is no formal opposition to AB 523.

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AMENDED IN ASSEMBLY MAY 3, 2021

AMENDED IN ASSEMBLY MARCH 29, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 523

Introduced by Assembly Member Nazarian

February 10, 2021

An act to add Section 14593.3 to the Welfare and Institutions Code, relating to the elderly.

LEGISLATIVE COUNSEL'S DIGEST

AB 523, as amended, Nazarian. Program of All-Inclusive Care for the Elderly.

Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center, as defined, in part, as a facility that includes a primary care clinic, so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option.

Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program), to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, and authorizes the State Department of Health Care Services to implement the PACE program by various means, including letters, or other similar instructions, without taking regulatory action. Under this authority, the department implemented various guidance on the PACE program in response to the state of emergency caused by the 2019 novel coronavirus ~~(COVID-19).~~ *(COVID-19), including authorizing a PACE organization*

to deliver prescribed services, including medically necessary services through telehealth. Existing law authorizes the department to enter into contracts with various entities to implement the PACE program and fully implement the single state agency responsibilities assumed by the department pursuant to those contracts, as specified.

This bill would *generally* require the department to make permanent the specified PACE program flexibilities instituted, on or before January 1, 2021, in response to the state of emergency caused by COVID-19 by means of all-facility letters or other similar instructions taken without regulatory ~~action.~~ *action, with prescribed modifications, such as instead limiting a PACE organization's use of telehealth to specified services, including conducting assessments for eligibility for enrollment in the PACE program, subject to the federal waiver process.* The bill would require the department to work with the federal Centers for Medicare and Medicaid Services to determine how to extend PACE program flexibilities approved during the COVID-19 emergency.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14593.3 is added to the Welfare and Institutions Code, to read:

14593.3. (a) The department shall make permanent the *following* changes in the California Program of All-Inclusive Care for the Elderly (PACE) program the department instituted, on or before January 1, 2021, in response to the state of emergency caused by the 2019 novel coronavirus (COVID-19) by means of all-facility letters, or other similar instructions, which were taken without regulatory action, in the areas described under paragraphs (1) to (7), ~~inclusive.~~ *inclusive:*

(1) (A) Telehealth.

~~(B) Medically necessary services may be delivered by a PACE organization via an in-person visit or telehealth, as deemed appropriate by the PACE organization. A PACE organization shall seek to implement any telehealth method that would provide remote consultation as an alternate means of providing critical, medically necessary services.~~

(B) A PACE organization may use telehealth, as defined in Section 2290.5 of the Business and Professions Code, to conduct

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assessments for eligibility for enrollment in the PACE program, or for service modifications, subject to the federal waiver process.

(2) (A) PACE enrollment agreements.

(B) A PACE organization shall be approved to collect and document a verbal agreement of enrollment in lieu of the participant signature normally required to complete the enrollment agreement for the PACE program. A PACE organization shall document the conversation of the verbal ~~agreement.~~ *agreement and shall obtain a written signature within 14 days of submission of the enrollment agreement.*

(3) (A) Adult Day Health Care (ADHC) services provided in the home.

(B) A PACE organization shall not be required to provide all ~~services at the center, and~~ *nursing services, as defined in Section 14550.6, at the center. The PACE interdisciplinary team* shall have flexibility to determine how to provide ~~basic~~ *those nursing* services to participants. Services may be provided via telehealth or other remote methods, including, but not limited to, check-in calls, health screening calls, ~~video conferencing, and meal delivery.~~ *and video conferencing, taking into account the participant's medical, physical, emotional, and social needs.*

~~(C) For purposes of subparagraph (B), "basic services" includes all of the following:~~

~~(i) Medical services.~~

~~(ii) Nursing services.~~

~~(iii) Nutrition services.~~

~~(iv) Occupational therapy.~~

~~(v) Physical therapy.~~

~~(vi) Psychiatric or psychological services.~~

~~(vii) Recreation or planned social activities.~~

~~(viii) Social services.~~

~~(ix) Speech therapy.~~

(4) (A) Involuntary disenrollments – Out of Service Area.

(B) ~~A~~ *As part of a plan of care, a* PACE organization shall not be required to submit a involuntary disenrollment request for a participant that has temporarily moved out of *the* service area. ~~A~~ *The location of the temporary move shall be within a ____ minute drive of the PACE center and shall not exceed a 30-day period unless extenuating circumstances exist. During a temporary move, as described in this subparagraph, a* PACE participant shall not

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be required to update their address with the county Medi-Cal office to ensure their continued enrollment in the PACE organization. A PACE organization shall retain responsibility for coordination of care and services and full financial ~~risk.~~ *risk in alignment with federal regulations.*

(5) (A) Facility beds.

(B) ~~A~~ *As part of a plan of care, a* PACE organization shall have the flexibility to place a participant in a facility that is out of their approved service area if there is a lack of available beds in the PACE organization's service area. ~~A~~ *The location of the temporary placement shall be within a ____ minute drive of the PACE center and shall not exceed a 30-day period unless extenuating circumstances exist. During a temporary placement, as described in this subparagraph, a* PACE organization shall retain responsibility for coordination of care and services and full financial ~~risk.~~ *risk in alignment with federal regulations.*

(6) (A) Marketing.

(B) A PACE organization shall have the flexibility to use a broker for marketing purposes as provided by the federal regulations on PACE. A PACE organization may use individuals and entities to market on their behalf, if the individuals or entities have been appropriately trained on PACE program requirements, and, specifically, participant rights, and requirements on participant enrollment and disenrollment.

(7) (A) Discharge planning.

(B) If a discharge planner at a PACE referral source, including, but not limited to, a hospital, emergency room, nursing home, or health plan, determines that a PACE plan would be an appropriate program to facilitate the patient's discharge and serve the patient's needs in their home or community, the discharge planner may ask the patient or the patient's representative if they would prefer to be contacted by a PACE organization. If the patient affirmatively answers, then all of the following apply:

(i) The discharge planner shall document in the patient's record that the patient or authorized representative consented to be contacted by a PACE organization.

(ii) The discharge planner may inform the PACE organization that the patient consented to being contacted by a PACE organization, and may provide information on how the patient or representative stated they wish to be contacted.

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(iii) The PACE organization may directly contact the patient or representative in the manner chosen by the patient or representative. The PACE organization may make one attempt to contact the patient or their representative by various means, including a phone call, email, or mail. If the individual or their representative indicates that the patient is uninterested in the PACE program or does not respond, the PACE organization shall not make further direct contact.

(b) The department shall work with the federal Centers for Medicare and Medicaid Services to determine how to extend PACE program flexibilities approved during the COVID-19 emergency.

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Legislative Analysis: Senate Bill 316

Same-Day Billing for Federally Qualified Health Centers

Background

Federally Qualified Health Centers (FQHC) provide physical, mental and dental health services with a focus on preventive care. Without a county hospital in Orange County, CalOptima contracts with 31 FQHCs that provided direct services to nearly 113,000 CalOptima members within the past year.

California is one of the few states that does not allow for mental and physical health visits on the same day. This requires a patient to wait at least 24 hours to receive mental health services after receiving primary care or dental services at an FQHC. FQHCs are reimbursed at a single bundled rate, known as the Prospective Payment System (PPS), for each qualifying patient visit. PPS is a fixed per-visit amount unique to each FQHC and predetermined by Medicaid. FQHCs in the Medi-Cal managed care system are provided a "wrap around" payment by the Department of Health Care Services (DHCS) for the difference between their PPS rate and the health plan payment.

Summary

No sooner than July 1, 2022, Senate Bill (SB) 316, introduced by Sen. Susan Talamantes Eggman, would allow a medical visit through the member's primary care provider and a mental health or dental visit as two separate FQHC visits at the same location on the same day. FQHCs would need to apply for adjustments to their PPS rates in order to be reimbursed for separate visits.

Impact

Although there is no immediate impact to CalOptima given that the FQHC wrap around payment is determined at the state level, SB 316 would increase members' access to services at contracted FQHCs. This would ensure over 190,000 CalOptima members assigned to an FQHC can access both primary care and mental health or dental services on the same day. As a result, the member would be able to receive better coordinated care, would no longer need to wait 24 hours to receive additional services, and would no longer rely on emergency room visits if the member requires physical health services after already receiving mental or dental services on the same day.

Support/Opposition

SB 316 is supported by CalOptima's state trade associations — the California Association of Health Plans and Local Health Plans of California. SB 316 is also supported by:

- Alameda Health Consortium
- AltaMed Health Services Corp.
- APLA Health
- Asian Health Services
- California Association of Public Hospitals and Health Systems
- California Association of Social Rehabilitation Agencies
- California Coverage & Health Initiatives
- CaliforniaHealth+ Advocates
- California Hospital Association
- California LGBTQ Health and Human Services Network
- California Pan-Ethnic Health Network
- California Psychological Association
- California School-Based Health Alliance
- Centers for Family Health and Education
- Coalition of Orange County Community Health Centers
- Community Clinic Association of Los Angeles County
- Community Health Systems
- Community Medical Centers
- Community Medical Wellness Centers
- County Behavioral Health Directors Association of California
- County Health Executives Association of California
- County Welfare Directors Association of California
- Courage California
- East Valley Community Health Center
- Eisner Health
- Fresno Metro Black Chamber of Commerce
- Golden Valley Health Centers
- Health Alliance of Northern California
- Health Center Partners of Southern California
- JWCH Institute
- Kheir Clinic
- Los Angeles LGBT Center
- National Association of Social Workers, California Chapter
- Neighborhood Healthcare
- North Coast Clinics Network
- Parktree Community Health Centers
- Pomona Community Health Center dba Park Tree Community Health Center
- Psychiatric Physicians Alliance of California
- Queenscare Health Centers
- Redwood Community Health Coalition
- Saban Community Clinic
- San Francisco Community Clinic Consortium
- San Ysidro Health
- South Central Family Health Center
- Southeast Asia Resource Action Center
- Tarzana Treatment Centers
- TCC Family Health
- The Children's Clinic
- The Los Angeles Trust for Children's Health
- TrueCare Venice Family Clinic
- Wesley Health Centers
- Western Center on Law and Poverty

There is no formal opposition to SB 316.

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SENATE BILL No. 316

Introduced by Senators Eggman and McGuire
(Principal coauthor: Assembly Member Aguiar-Curry)
(Coauthors: Senators Dahle, Hertzberg, Jones, Nielsen, and Wiener)
(Coauthors: Assembly Members Frazier, Cristina Garcia, Eduardo Garcia, Lorena Gonzalez, Mathis, Patterson, Robert Rivas, and Stone)

February 4, 2021

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 316, as introduced, Eggman. Medi-Cal: federally qualified health centers and rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist.

This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or

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treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.

This bill would also include a licensed acupuncturist within those health professionals covered under the definition of a "visit." The bill would require the department, by July 1, 2022, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to reflect certain changes described in the bill, and to seek necessary federal approvals. The bill would also make conforming and technical changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. ~~Prior to~~ *Before* January 1, 2004, FQHC and RHC per-visit rates shall be

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adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of ~~services~~ *service* provided by the FQHC or RHC. Rate changes based on a change in the scope of ~~services~~ *service* provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

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(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of ~~services~~ *service* defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section ~~413) of Subchapter B of Chapter 4~~ *413.1)* of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of ~~services~~ *service* is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a ~~scope-of-service~~ *scope of service* change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for ~~scope-of-service~~ *scope of service* changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a ~~scope-of-service~~ *scope of service* rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of ~~services~~ *service* provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a ~~scope-of-service~~ *scope of service* rate change request within 90 days of the beginning of the

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following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved ~~scope-of-service~~ *scope of service* change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a ~~scope-of-service~~ *scope of service* change, the adjusted reimbursement rate for that ~~scope-of-service~~ *scope of service* change shall be made retroactive to the date the ~~scope-of-service~~ *scope of service* change was initially implemented. ~~Scope-of-service~~ *Scope of service* changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision ~~*(l)*~~ *(m)*. These supplemental payments shall be determined separately from the ~~scope-of-service~~ *scope of service* adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

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(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a ~~physician and surgeon,~~ *medical doctor,* osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a

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four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, ~~or~~ a marriage and family ~~therapist.~~ *therapist, or a licensed acupuncturist.*

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these

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services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding ~~any other provision of~~ this section, ~~no later than~~ *by* July 1, 2018, a visit shall include a marriage and family therapist.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in ~~scope of service~~ *scope-of-service* request if both of the following requirements are met:

(i) The change in ~~scope of service~~ *scope-of-service* request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in ~~scope of service~~ *scope-of-service* request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in ~~scope of service~~ *scope-of-service* request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, ~~prior to~~ *before* January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in ~~scope of service~~ *scope-of-service* request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the

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FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its *new* FQHC or RHC ~~enrollment approval,~~ *provider number,* and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

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(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined by ~~paragraph (2) of~~ subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health ~~prior to~~ *before* January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added ~~prior to~~ *before* January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health ~~prior to~~ *before* January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of ~~services~~ *service* provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a ~~scope-of-service~~ *scope of service* adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude ~~or~~ *nor* otherwise limit the right of the FQHC or RHC to request a ~~scope-of-service~~ *scope of service* adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as ~~scope-of-service~~ *scope of service* changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable ~~scope-of-service~~ *scope of service* adjustments as provided in subdivision (e).

(l) (1) For purposes of this subdivision, the following definitions apply:

(A) "Mental health visit" means a face-to-face encounter between an FQHC or RHC patient and a psychiatrist, clinical psychologist, licensed clinical social worker, or marriage and family therapist.

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(B) "Dental visit" means a face-to-face encounter between an FQHC or RHC patient and a dentist, dental hygienist, or registered dental hygienist in alternative practice.

(C) "Medical visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services.

(2) A maximum of two visits, as defined in subdivision (g), that take place on the same day at a single location shall be reimbursed when one or both of the following conditions exists:

(A) Following the first visit, the patient suffers illness or injury that requires additional diagnosis or treatment.

(B) The patient has a medical visit and a mental health visit or a dental visit.

(3) (A) Notwithstanding subdivision (e), for purposes of establishing an FQHC or RHC rate, if an FQHC or RHC includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit, then the FQHC or RHC may elect to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, the FQHC or RHC shall bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits.

(B) The department shall develop and adjust all appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and shall facilitate the calculation of the adjusted rates.

(C) An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this paragraph shall not constitute a change in scope of service within the meaning of subdivision (e).

(D) An FQHC or RHC that applies for an adjustment to its rate pursuant to this paragraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

(4) The department, by July 1, 2022, shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this subdivision.

~~(l)~~

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(m) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a ~~scope-of-service~~ *scope of service* change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the ~~scope-of-service~~ *scope of service* change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for ~~scope-of-service~~ *scope of service* change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. ~~Any scope-of-service~~ *A scope of service* change request under this subdivision approved by the department shall be retroactive to the

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first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a ~~scope-of-service~~ *scope of service* change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for ~~scope-of-service~~ *scope of service* change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable ~~scope-of-service~~ *scope of service* adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on

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whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

~~(m)~~

(n) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into

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with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a ~~scope-of-service~~ *scope of service* change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the ~~scope-of-service~~ *scope of service* change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a ~~scope-of-service~~ *scope of service* change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. ~~Any scope-of-service~~ *A scope of service* change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but *in no case shall* the effective date ~~shall not~~ be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts

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with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for ~~scope-of-service~~ *scope of service* change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable ~~scope-of-service~~ *scope of service* adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

~~(n)~~

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, ~~scope-of-service~~ *scope of service* changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under ~~all other provisions of law~~ *the laws* of this state.

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~~(o)~~

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

~~(p)~~

(q) The department shall implement this section only to the extent that federal financial participation is available.

~~(q)~~

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions ~~*(l)* and (m)~~ *(m) and (n)* by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the ~~provisions of subdivisions *(l)* and (m),~~ *requirements of subdivisions (m) and (n),* including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days ~~prior to~~ *before* the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

21. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2021-22

Contact

Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Action

Adopt the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period July 1, 2021 through June 30, 2022.

Background

Section 5.2.(b) (1) of the CalOptima Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion

The proposed schedule of meetings for the period July 1, 2021 through June 30, 2022 is as follows:

1. The Board of Directors will meet at 2 p.m. on the first Thursday of each month, with the following exceptions:
   - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2021 that requires Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

   - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2022. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 2:00 p.m. on the third Thursday in the months of September, November, February and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the second Wednesday in the months of September, December, March and June.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided. The proposed FY 2021-22 Board of Directors Meeting Schedule is attached.

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Fiscal Impact

The fiscal impact for FY 2021-22 Board of Directors Meetings is up to $27,000 in per diem costs, and up to $9,000 in mileage reimbursement for certain Board members. Funding is included as part of the proposed CalOptima FY 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Proposed Schedule of Meetings of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2021 through June 30, 2022

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
July 1, 2021 – June 30, 2022

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 2:00 p.m.**	**Quality Assurance Committee** **Quarterly – Second Wednesday** **Meeting Time: 3:00 p.m.**
July 2021^		
August 5, 2021		
September 2, 2021	September 16, 2021	September 8, 2021
October 7, 2021		
November 4, 2021	November 18, 2021	
December 2, 2021		December 8, 2021
January 2022^		
February 3, 2022	February 17, 2022	
March 3, 2022		March 9, 2022
April 7, 2022		
May 5, 2022	May 19, 2022	
June 2, 2022[1]		June 8, 2022

^No Regular meeting scheduled
[1] Organizational Meeting

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Financial Summary

April 30, 2021

Board of Directors Meeting

June 3, 2021

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $14.2 million, favorable to budget $19.8 million or 351.0%
  - YTD: $35.8 million, favorable to budget $61.6 million or 238.4%
- Enrollment
  - MTD: 833,848 members, favorable to budget 20,023 or 2.5%
  - YTD: 8,036,147 member months, favorable to budget 64,361 or 0.8%
- Revenue
  - MTD: $334.3 million, favorable to budget $63.3 million or 23.4% driven by Medi-Cal (MC) line of business (LOB):
    - $52.9 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
    - $5.7 million favorable volume related variance
  - YTD: $3.4 billion, favorable to budget $357.5 million or 11.9% driven by MC LOB:
    - Fiscal year (FY) 2019 hospital Directed Payments (DP) and the pharmacy benefit transition postponement
    - Offset by the Bridge Period Gross Medical Expenditure (GME) risk corridor and Proposition 56 risk corridor reserve

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $310.9 million, unfavorable to budget $45.9 million or 17.3% driven by MC LOB:
    - Prescription Drugs expense unfavorable variance of $57.4 million due to postponement of pharmacy benefit transition
    - Provider Capitation expense unfavorable variance of $4.0 million
    - Offset by Facilities Claims expense favorable variance of $7.6 million
    - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $6.5 million
  - YTD: $3.2 billion, unfavorable to budget $305.4 million or 10.4% driven by:
    - MC LOB FY 2019 hospital DP and pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic
    - OCC LOB unfavorable to budget $21.1 million or 8.5% due to higher Provider Capitation and Facilities Claims expenses
- Administrative Expenses
  - MTD: $11.5 million, favorable to budget $1.5 million or 11.5%
  - YTD: $112.4 million, favorable to budget $14.3 million or 11.3%
- Net Investment & Other Income
  - MTD: $2.2 million, favorable to budget $1.0 million or 79.7%
  - YTD: $7.6 million, unfavorable to budget $4.9 million or 39.1% due to decrease in long-term bond values that are affected by higher interest rates

FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 93.0% (93.0% excluding DP), Budget 97.8%
  - YTD: Actual 95.8% (95.6% excluding DP), Budget 97.1%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.4% (3.4% excluding DP), Budget 4.8%
  - YTD: Actual 3.3% (3.5% excluding DP), Budget 4.2%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.88
  - Net position: $1.1 billion, including required Tangible Net Equity (TNE) of $104.6 million

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Enrollment Summary: April 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
116,473	111,130	5,343	4.8%	SPD	1,148,397	1,109,539	38,858	3.5%
521	464	57	12.3%	BCCTP	5,153	4,768	385	8.1%
296,618	319,366	(22,748)	(7.1%)	TANF Child	2,927,391	3,110,781	(183,390)	(5.9%)
105,430	95,974	9,456	9.9%	TANF Adult	1,001,024	935,331	65,693	7.0%
2,991	3,523	(532)	(15.1%)	LTC	31,901	35,140	(3,239)	(9.2%)
282,881	255,706	27,175	10.6%	MCE	2,639,333	2,498,714	140,619	5.6%
12,031	11,930	101	0.8%	WCM	116,065	119,316	(3,251)	(2.7%)
816,945	**798,093**	**18,852**	**2.4%**	**Medi-Cal Total**	**7,869,264**	**7,813,589**	**55,675**	**0.7%**
14,744	**13,896**	**848**	**6.1%**	**OneCare Connect**	**146,762**	**140,143**	**6,619**	**4.7%**
1,764	**1,378**	**386**	**28.0%**	**OneCare**	**16,241**	**13,780**	**2,461**	**17.9%**
395	**458**	**(63)**	**(13.8%)**	**PACE**	**3,880**	**4,274**	**(394)**	**(9.2%)**
833,848	**813,825**	**20,023**	**2.5%**	**CalOptima Total**	**8,036,147**	**7,971,786**	**64,361**	**0.8%**

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Financial Highlights: April 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
833,848	813,825	20,023	2.5%	Member Months	8,036,147	7,971,786	64,361	0.8%
334,271,179	270,992,559	63,278,620	23.4%	Revenues	3,368,983,160	3,011,444,003	357,539,157	11.9%
310,881,718	264,952,742	(45,928,976)	(17.3%)	Medical Expenses	3,228,449,663	2,923,068,295	(305,381,368)	(10.4%)
11,457,498	12,939,673	1,482,175	11.5%	Administrative Expenses	112,383,053	126,707,799	14,324,746	11.3%
11,931,963	**(6,899,856)**	**18,831,819**	**272.9%**	**Operating Margin**	**28,150,444**	**(38,332,091)**	**66,482,535**	**173.4%**
2,246,690	1,250,000	996,690	79.7%	Non Operating Income (Loss)	7,613,520	12,500,000	(4,886,480)	(39.1%)
14,178,653	**(5,649,856)**	**19,828,509**	**351.0%**	**Change in Net Assets**	**35,763,964**	**(25,832,091)**	**61,596,055**	**238.4%**
93.0%	97.8%	4.8%		Medical Loss Ratio	95.8%	97.1%	1.2%	
3.4%	4.8%	1.3%		Administrative Loss Ratio	3.3%	4.2%	0.9%	
3.6%	(2.5%)	6.1%		Operating Margin Ratio	0.8%	(1.3%)	2.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.0%	97.8%	4.8%		*MLR (excluding Directed Payments)	95.6%	97.1%	1.5%	
3.4%	4.8%	1.3%		*ALR (excluding Directed Payments)	3.5%	4.2%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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Consolidated Performance Actual vs. Budget: April 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
14.1	(5.9)	20.1	Medi-Cal	26.7	(31.2)	57.9
(2.2)	(1.1)	(1.1)	OCC	(1.8)	(9.0)	7.2
(0.4)	(0.1)	(0.3)	OneCare	(0.4)	0.1	(0.5)
0.3	0.2	0.2	PACE	3.6	1.8	1.8
11.9	**(6.9)**	**18.8**	**Operating**	**28.2**	**(38.3)**	**66.5**
2.2	1.3	1.0	Inv./Rental Inc, MCO tax	7.6	12.5	(4.9)
2.2	**1.3**	**1.0**	**Non-Operating**	**7.6**	**12.5**	**(4.9)**
14.2	**(5.6)**	**19.8**	**TOTAL**	**35.8**	**(25.8)**	**61.6**

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Consolidated Revenue & Expenses: April 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	522,033	282,881	12,031	816,945	14,744	1,764	395	833,848
REVENUES								
Capitation Revenue	152,217,866	$ 125,639,002	$ 25,198,823	$ 303,055,691	$ 25,675,190	$ 2,317,474	$ 3,222,825	$ 334,271,179
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	152,217,866	125,639,002	25,198,823	303,055,691	25,675,190	2,317,474	3,222,825	334,271,179
MEDICAL EXPENSES								
Provider Capitation	40,421,238	48,634,439	10,313,013	99,368,690	10,858,425	642,070		110,869,185
Facilities	22,804,486	22,944,355	6,280,789	52,029,630	4,974,304	798,450	502,609	58,304,993
Professional Claims	19,669,984	9,852,444	1,353,058	30,875,485	1,105,132	153,167	834,571	32,968,356
Prescription Drugs	21,735,785	28,955,103	6,689,320	57,380,208	6,513,136	831,957	287,700	65,013,001
MLTSS	28,863,126	2,814,731	1,790,628	33,468,485	1,395,588	74,666	60,791	34,999,531
Medical Management	2,208,456	1,355,006	295,256	3,858,719	1,218,308	29,184	863,935	5,970,146
Quality Incentives	862,790	549,833	35,719	1,448,342	215,550		4,938	1,668,830
Reinsurance & Other	493,285	334,482	11,168	838,934	114,727	2,502	131,511	1,087,675
Total Medical Expenses	137,059,150	115,440,393	26,768,952	279,268,495	26,395,172	2,531,996	2,686,055	310,881,718
Medical Loss Ratio	90.0%	91.9%	106.2%	92.2%	102.8%	109.3%	83.3%	93.0%
GROSS MARGIN	**15,158,717**	**10,198,608**	**(1,570,129)**	**23,787,196**	**(719,982)**	**(214,522)**	**536,769**	**23,389,461**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,853,451	665,379	70,300	90,648	7,679,778
Professional fees				109,977	35,486	16,000	123	161,586
Purchased services				957,216	120,207	8,371	81,552	1,167,346
Printing & Postage				465,350	53,763	4,495	3	523,610
Depreciation & Amortization				349,607			2,013	351,620
Other expenses				1,185,548	10,772		12,781	1,209,101
Indirect cost allocation & Occupancy				(269,658)	585,999	41,437	6,678	364,457
Total Administrative Expenses				9,651,492	1,471,604	140,604	193,798	11,457,498
Admin Loss Ratio				3.2%	5.7%	6.1%	6.0%	3.4%
INCOME (LOSS) FROM OPERATIONS				14,135,704	(2,191,586)	(355,126)	342,972	11,931,963
INVESTMENT INCOME								957,319
TOTAL MCO TAX				1,289,300				1,289,300
OTHER INCOME				70				70
CHANGE IN NET ASSETS				**$ 15,425,075**	**$ (2,191,586)**	**$ (355,126)**	**$ 342,972**	**$ 14,178,653**
BUDGETED CHANGE IN NET ASSETS				(5,924,528)	(1,051,533)	(73,967)	150,172	(5,649,856)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 21,349,603	$ (1,140,053)	$ (281,159)	$ 192,800	$ 19,828,509

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Consolidated Revenue & Expenses: April 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,113,866	2,639,333	116,065	7,869,264	146,762	16,241	3,880	8,036,147
REVENUES								
Capitation Revenue	1,568,583,845	$ 1,228,205,830	$ 236,403,582	$ 3,033,193,256	$ 282,901,738	$ 20,506,610	$ 32,381,555	$ 3,368,983,160
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,568,583,845	1,228,205,830	236,403,582	3,033,193,256	282,901,738	20,506,610	32,381,555	3,368,983,160
MEDICAL EXPENSES								
Provider Capitation	380,852,852	451,405,569	118,538,426	950,796,846	120,967,529	5,660,181		1,077,424,557
Facilities	238,686,552	250,131,255	22,173,123	510,990,930	50,094,789	5,983,997	7,250,782	574,320,498
Professional Claims	197,833,932	92,644,578	10,874,578	301,353,087	10,010,129	791,036	6,595,795	318,750,047
Prescription Drugs	202,306,207	257,644,564	54,750,221	514,700,992	60,257,423	6,186,368	2,860,385	584,005,168
MLTSS	330,676,553	28,615,982	18,565,135	377,857,670	13,965,761	338,890	633,222	392,795,542
Medical Management	23,483,815	14,000,758	2,971,720	40,456,294	10,968,772	355,686	8,592,551	60,373,302
Quality Incentives	10,653,751	5,205,815	562,489	16,422,056	2,161,305		132,859	18,716,220
Reinsurance & Other	113,075,668	86,405,566	119,236	199,600,471	1,302,010	2,527	1,159,321	202,064,330
Total Medical Expenses	1,497,569,330	1,186,054,088	228,554,927	2,912,178,345	269,727,719	19,318,684	27,224,914	3,228,449,663
Medical Loss Ratio	95.5%	96.6%	96.7%	96.0%	95.3%	94.2%	84.1%	95.8%
GROSS MARGIN	**71,014,514**	**42,151,742**	**7,848,655**	**121,014,911**	**13,174,019**	**1,187,926**	**5,156,641**	**140,533,497**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				68,293,844	6,963,717	815,917	1,125,869	77,199,347
Professional fees				1,217,422	189,849	172,973	1,273	1,581,518
Purchased services				8,224,168	920,127	83,000	215,596	9,442,891
Printing & Postage				2,566,478	778,171	54,907	115,763	3,515,320
Depreciation & Amortization				3,255,290			20,246	3,275,536
Other expenses				13,530,317	269,333	653	55,356	13,855,658
Indirect cost allocation & Occupancy				(2,801,099)	5,859,986	414,374	39,521	3,512,783
Total Administrative Expenses				94,286,420	14,981,183	1,541,825	1,573,624	112,383,053
Admin Loss Ratio				3.1%	5.3%	7.5%	4.9%	3.3%
INCOME (LOSS) FROM OPERATIONS				26,728,491	(1,807,164)	(353,899)	3,583,016	28,150,444
INVESTMENT INCOME								5,649,770
TOTAL MCO TAX				1,948,795				1,948,795
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				905				905
CHANGE IN NET ASSETS				**$ 28,692,241**	**$ (1,807,164)**	**$ (353,899)**	**$ 3,583,016**	**$ 35,763,964**
BUDGETED CHANGE IN NET ASSETS				(31,164,611)	(9,024,141)	96,635	1,760,026	(25,832,091)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 59,856,852	$ 7,216,977	$ (450,534)	$ 1,822,990	$ 61,596,055

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Balance Sheet: As of April 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$277,938,307	Accounts Payable	$19,671,189
Investments	996,185,313	Medical Claims liability	1,025,920,538
Capitation receivable	327,861,491	Accrued Payroll Liabilities	14,283,350
Receivables - Other	46,855,643	Deferred Revenue	41,340,969
Prepaid expenses	10,625,866	Deferred Lease Obligations	133,028
		Capitation and Withholds	140,154,180
Total Current Assets	**1,659,466,621**	**Total Current Liabilities**	**1,241,503,254**
Capital Assets			
Furniture & Equipment	46,910,603		
Building/Leasehold Improvements	5,916,528		
505 City Parkway West	51,646,314		
	104,473,444		
Less: accumulated depreciation	(58,754,500)		
Capital assets, net	45,718,943	Other (than pensions) post employment benefits liability	26,256,301
Other Assets		Net Pension Liabilities	27,427,582
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,295,187,136**
Cash and Cash Equivalents	(704,041)		
Long-term Investments	589,518,163	Deferred Inflows	
Total Board-designated Assets	588,814,122	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
Total Other Assets	645,913,035	Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
TOTAL ASSETS	**2,351,098,600**	Net Position	
		TNE	104,628,915
Deferred Outflows		Funds in Excess of TNE	956,266,347
Contributions	1,047,297	**TOTAL NET POSITION**	1,060,895,261
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,362,759,670**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,362,759,670**

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CalOptima
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Board Designated Reserve and TNE Analysis: As of April 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	161,032,740				
	Tier 1 - MetLife	160,028,388				
	Tier 1 - Wells Capital	160,217,850				
Board-designated Reserve		481,278,978	334,405,978	522,563,789	146,873,000	(41,284,811)
TNE Requirement	Tier 2 - MetLife	107,535,145	104,628,915	104,628,915	2,906,230	2,906,230
	Consolidated:	**588,814,122**	**439,034,892**	**627,192,703**	**149,779,230**	**(38,378,581)**
	Current reserve level	*1.88*	*1.40*	*2.00*		

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CalOptima
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Board of Directors Meeting
June 3, 2021

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- Contract Year (CY) 2019 Medical Loss Ratio (MLR) Desk Review:

  On April 28, 2021, CalOptima received notification from Actuarial Research Corporation (ARC) that they will be facilitating the review of CY 2019 MLR Reports for OneCare on behalf of the Centers for Medicare & Medicaid Services (CMS). Regulatory Affairs & Compliance (RAC) is awaiting details and instructions from ARC and will work with Finance on deliverables, as needed.

- 2021 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2021. The validation audit began in March and is expected to conclude in June 2021. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

  The webinar validation took place on April 6, 2021. Following the webinar validation, CalOptima's independent auditor Advent requested sample selections for each of the

reporting measures. CalOptima is working to collect the documents requested for submission ahead of the deadline.

- CY 2019 Medicare Part D Improper Payment Measure (Part D IPM) (*applicable to OneCare and OneCare Connect*):

  On January 15, 2021, CMS informed CalOptima that its OneCare and OneCare Connect contracts have been selected to participate in the CY 2019 Medicare Part D Improper Payment Measure (Part D IPM) audit, formerly known as the Payment Error Related to Prescription Drug Event Validation (PEPV). CMS conducts the Part D IPM audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2019 payments.

  On January 29, 2021, CMS informed CalOptima that it had selected two (2) PDEs for review --- one for OneCare and one for OneCare Connect. On March 9, 2021, CalOptima took advantage of the early submission window and submitted documentation for both sample selections to CMS. On March 12, 2021, CMS informed CalOptima that the sample for OneCare passed the element check. On April 1, 2021, CMS informed CalOptima that the sample for OneCare Connect passed the element check. No further action is required for the activity at this time.

- CY 2015 Medicare Part C National Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit.

  After suspending audit activities on March 30, 2020, due to the public health emergency, CMS resumed audit activities on September 14, 2020. The submission window closed on April 23, 2021. CalOptima has concluded its submission for this audit and is awaiting results from CMS

2. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare plan sponsors are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

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2 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. CalOptima submitted the full set of requested PDE samples to Myers & Stauffer ahead of the February 2, 2021, deadline. CalOptima has completed submission of all deliverables and is pending feedback from the auditor.

On April 1, 2021, Myers & Stauffer notified CalOptima they have provided a new documentation request list and will be conducting two sets of interviews during the week of April 12, 2021. On April 12, 2021 and April 15, 2021, Myers & Stauffer hosted a series of interview/conference calls to discuss CalOptima's oversight of delegated entities, policies and procedures related to fraud, waste, and abuse (FWA), and reporting of shared and/or intercompany expenses as they relate to PACE. The exit conference has been tentatively scheduled for June 18, 2021.

3. Medi-Cal

- Nothing to Report

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of April 2021.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of January 2021 – March 2021 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for six (6) consecutive months for Medi-Cal standard appeals.

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
January 2021	98%	61%
February 2021	98%	77%
March 2021	98%	52%

➢ CalOptima's Audit & Oversight (A&O) department escalated the corrective action plan (CAP) that was previously issued to an immediate corrective action plan (ICAP), as

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issues with non-timely processing of Medi-Cal standard appeals appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals. In addition, CalOptima's Audit & Oversight department has increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities.

2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	100%	0%	6.25%
February 2021	100%	100%	100%	72.22%	11.76%
March 2021	100%	100%	100%	85.71%	42.86%

➢ Based on a focused review of seven (7) Medi-Cal standard appeals for March 2021, the lower compliance scores of 85.71% was due to one (1) file exceed the sixth (6th) grade reading level.

➢ Based on a focused review of seven (7) Medi-Cal standard appeals for March 2021, the lower compliance scores of 42.86% was due to untimely resolution of four (4) standard appeals.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
January 2021	10%	100%	100%	0%	100%
February 2021	100%	100%	100%	66.7%	100%
March 2021	100%	100%	100%	92.30%	7.69%

➢ Based on a focused review of thirteen (13) Medi-Cal expedited appeals for March 2021, the lower compliance score of 92.30% was due to one (1) file exceeding the sixth (6th) grade reading level.

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- Based on a focused review of thirteen (13) Medi-Cal expedited appeals for March 2021, the lower compliance score of 7.69% was due to untimely resolution of twelve (12) expedited appeals.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	94.4%	77.8%	77.8%
February 2021	100%	100%	95%	70%	90%
March 2021	100%	100%	100%	90%	95%

- Based on a focused review of twenty (20) Medi-Cal standard for March 2021, the lower compliance score of 90% was due to incomplete resolution of two (2) grievances.

- Based on a focused review of twenty (20) Medi-Cal standard grievances for March 2021, the lower compliance score of 95% was due to untimely resolution of one (1) grievance.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
January 2021	100%	100%	5%	100%	50%
February 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- No significant trends to report in March 2021.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
January 2021	100%	86%	93%	93%	93%	100%	93%
February 2021	100%	90%	60%	100%	100%	100%	80%
March 2021	78%	67%	100%	89%	67%	100%	89%

  - Based on a focused review of nine (9) Medi-Cal standard prior for March 2021, the lower compliance score of 78% was due to incorrect file classification of two (2) standard prior authorizations.

  - Based on a focused review of nine (9) Medi-Cal standard for March 2021, the lower compliance score of 67% for resolution timeliness was due to three (3) files not meeting the TAT for processing standard authorization request.

  - Based on a focused review of nine (9) Medi-Cal standard prior authorizations for March 2021, the lower compliance score of 89% for clinical decision-making review was due to one (1) file missing documentation.

  - Based on a focused review of nine (9) Medi-Cal standard prior authorizations for March 2021, the lower compliance score of 67% for processing accuracy was due to three (3) files not following the medical necessity guidelines.

  - Based on a focused review of nine (9) Medi-Cal standard prior authorizations for March 2021, the lower compliance score of 89% for accuracy of member notice content was due to one (1) file not having evidence of delay letter that was sent to the provider.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
January 2021	100%	100%	100%	100%	100%	100%	100%
February 2021	100%	90%	90%	100%	100%	100%	100%
March 2021	100%	100%	82%	100%	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of eleven (11) Medi-Cal urgent prior authorizations for March 2021, the lower compliance score of 82% for provider and member notification timeliness was due to two (2) files missing the provider fax confirmations.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	100%	0%	100%
February 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
March 2021	100%	100%	100%	66%	66%

- Based on a focused review of three (3) OneCare standard appeals for March 2021, the lower compliance score of 66% was due to one (1) file exceeding the sixth (6th) grade reading level.

- Based on a focused review of three (3) OneCare standard for March 2021, the lower compliance score of 66% were due to untimely resolution of one (1) standard appeal.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	100%	50%	100%
February 2021	100%	100%	100%	100%	100%
March 2021	100%	100%	100%	100%	100%

- No significant trends to report in March 2021.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	100%	0%	100%
February 2021	100%	70%	100%	30%	100%
March 2021	100%	100%	100%	285.7%	85.71%

  - Based on a focused review of seven (7) OneCare Connect standard appeals for March 2021, the lower compliance score of 28.57% were due to five (5) files missing documentation.

  - Based on a focused review of seven (7) OneCare Connect standard appeals for March 2021, the lower compliance scores of 85.71% was due to untimely resolution of one (1) standard appeal.

- OneCare Connect GARS: Expedited Appeals

Month(s)	Classification Score	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within 72 Hours of Receipt
January 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2021	100%	100%	100%	100%	0%
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - No significant trends to report in March 2021.

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- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance within ≤ 30 Calendar Days of Receipt
January 2021	100%	100%	100%	66.67%	100%
February 2021	100%	100%	100%	73.33%	100%
March 2021	100%	100%	100%	93.33%	100%

  - Based on a focused review of fourteen (14) OneCare Connect standard for March 2021, the lower compliance score of 93.33% was due to one (1) file having incomplete resolution.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
January 2021	100%	100%	70%	90%	100%	90%	100%
February 2021	100%	100%	70%	90%	100%	100%	100%
March 2021	100%	90%	90%	70%	90%	70%	90%

  - Based on a focused review of ten (10) OneCare Connect standard prior authorizations for March 2021, the lower compliance score of 90% for resolution timeliness was due to one (1) file request not being triaged for nurse review in a timely manner.

  - Based on a focused review of ten (10) OneCare standard prior authorizations for March 2021, the lower compliance score of 90% for provider and member notification timeliness was due to one (1) delay letter not meeting timeliness requirements.

  - Based on a focused review of ten (10) OneCare Connect standard prior authorizations for March 2021, the lower compliance score of 70% for clinical decision-making review was due to three (3) files not following the medical hierarchy guidelines.

  - Based on a focused review of ten (10) OneCare Connect standard prior authorizations for March 2021, the lower compliance score of 90% was due to one (1) file being processed inaccurately.

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- Based on a focused review of ten (10) OneCare standard prior authorizations for March 2021, the lower compliance score of 70% for written response in member's preferred language was due to three (3) Notice of Actions (NOA) not being fully translated in the member's preferred language.

- Based on a focused review of ten (10) OneCare standard prior authorizations for March 2021, the lower compliance score of 90% for accuracy of member noticed content was due to one (1) file not having evidence of the delay letter being sent to the member.

- OneCare Connect Utilization Management: Expedited Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
January 2021	100%	100%	80%	70%	100%	100%	90%
February 2021	100%	100%	100%	100%	100%	90%	60%
March 2021	100%	100%	80%	100%	100%	90%	100%

- Based on a focused review of ten (10) One Care expedited prior authorizations for March 2021, the low compliance score of 80% for provider and member notification timeliness was due to two (2) files failing to notify the provider timely of the decision.

- Based on a focused review of ten (10) One Care Connect expedited prior authorizations for March 2021, the low compliance score of 90% for written response in member's preferred language was due to one (1) NOA letter not being sent in the member's preferred language.

5. Internal Audits: [a\]

- During the first quarter of 2021, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Medicare (OneCare and OneCare Connect) and Medi-Cal Claims to ensure compliance with universe, timeliness and accuracy, as applicable, for the review period of January 1, 2020 – September 30, 2020.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Claims Medicare (OneCare)

Area Assessed	Acknowledgement Timeliness	Processing Accuracy	Resolution Timeliness	Interest Accuracy	Check Clearing Timeliness
ODAG-3 Non-Contracted Provider Paid Claims	90%	100%	100%	100%	100%
ODAG-3 Contracted/ Non-Contracted Denied Claims	100%	100%	100%	N/A	N/A

- ODAG-3 Requests for Payment Organization Determinations

  - Acknowledgement Timeliness
    - One (1) of the ten file samples reviewed had untimely acknowledgement of the claim.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Medicare (OneCare) universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- Claims Medicare (OneCare Connect)

  - No significant trends to report during this review of CalOptima's OneCare Connect claims.

Area Assessed	Acknowledgement Timeliness	Processing Accuracy	Resolution Timeliness	Interest Accuracy	Check Clearing Timeliness
SARAG-3 Non-Contracted Provider Paid Claims	100%	100%	100%	100%	100%
SARAG-3 Contracted/ Non-Contracted Denied Claims	100%	100%	100%	N/A	N/A

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- Claims Med-Cal

  - No significant trends to report during this review of CalOptima's Medi-Cal claims.

Area Assessed	Acknowledgement Timeliness	Processing Accuracy	Resolution Timeliness	Interest Accuracy	Check Clearing Timeliness
State Supported Services	100%	100%	100%	100%	100%
Non-Contracted Emergency Claims	100%	100%	100%	100%	100%
Non-Contracted Family Planning Claims	100%	100%	100%	100%	100%

6. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2021	86%	96%	97%	86%	91%	95%	96%	82%	94%	99%	97%	89%	97%
February 2021	89%	95%	98%	94%	93%	93%	99%	92%	95%	100%	95%	89%	97%
March 2021	87%	95%	100%	92%	84%	78%	86%	99%	94%	100%	77%	89%	99%

  - Based on a focused review of select files, eight (8) health networks drove the lower compliance score for timeliness during the month March 2021. Of the one-hundred eighty-nine (189) files submitted in the aggregate by eight (8) health networks, forty-one (41) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
    - Failure to meet timeframe for decision (Urgent – 72 hours, Routine – 5 business days, and Extended– 14 calendar days)
    - Failure to meet timeframe for provider initial notification (24 hours)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for member notification (2 business days)

  - Based on a focused review of select files, six (6) health networks drove the lower compliance score for clinical decision making (CDM) during the month of March 2021. Of the fifty-four (54) files submitted in the aggregate by six (6) health networks,

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twenty-eight (28) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
- Failure to obtain adequate clinical information
- Failure to include appropriate professional that makes decision
- Failure to cite criteria for decision

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance score for letter criteria during the month of March 2021. Of the forty-three (43) files submitted in the aggregate by five (5) health networks, nine (9) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
- Failure to provide letter in member preferred language
- Failure to provide why the request did not meet the criteria in lay language
- Failure to provide description of service in lay language

➢ Based on the overall universe of Medi-Cal authorizations for January 2021, CalOptima's health networks received an aggregate compliance score of 72.73% for timely processing of routine authorization requests and a compliance score of 99.91% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2021	95%	97%	97%	92%
February 2021	94%	98%	98%	96%
March 2021	86%	97%	97%	90%

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance score for Paid Claims Timeliness during the month of March 2021. Of the fifty (50) files submitted in the aggregate by the five (5) health networks, sixteen (16) files were deficient due to the failure to meet non-contracted paid claim timeliness (30 calendar day from date of claim receipt).

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- Based on a focused review of select files, three (3) health networks drove the lower compliance score for Paid Claims Accuracy during the month of March 2021. Of the thirty-five (35) files submitted in the aggregate by three (3) health networks, four (4) files were deficient due to the failure to pay interest and missing documentation for clean claims processing.

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for Denied Claims Timeliness during the month of March 2021. Of the one-hundred fifty-five (155) files submitted in the aggregate by five (5) health networks, ten (10) files were deficient due to the failure to meet non-contracted denied claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, nine (9) health networks drove the lower compliance score for Denied Claims Accuracy during the month of March 2021. Of the two hundred-eighty (280) files submitted in the aggregate by nine (9) health networks, thirty-two (32) files were deficient for accuracy criteria. The deficiency for the lower scores for accuracy were due to the following:
  - Failure to provide all necessary documentation for clean claims processing; and
  - Failure to provide a valid claims denial reason, or denying in error (e.g., invalid CPT code or ICD code).

- Based on the overall universe of Medi-Cal claims for January 2021, CalOptima's health networks received an overall compliance score of 92% for timely processing of claims.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
January 2021	100%	100%	91%	100%	91%	100%	92%	93%
February 2021	98%	100%	93%	100%	89%	100%	88%	100%
March	93%	100%	89%	100%	93%	100%	97%	98%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness during the month of March 2021. Of the two (2) files submitted by the one (1) health network, one (1) file was deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Expedited – 72 hours)
  - Failure to meet timeframe for provider notification (72 hours)
  - Failure to meet timeframe for member written notification (72 hours)
  - Failure to meet timeframe for member oral notification (72 hours)

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for letter criteria during the month of March 2021. Of the fifty-six (56) files submitted in the aggregate by five (5) health networks, twenty-eight (28) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to utilize CMS approved letter template
  - Failure to provide letter with CalOptima logo
  - Failure to provide description of service in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for January 2021 CalOptima's health networks received an overall compliance score 93% for timely processing of standard Part C authorization requests and 80% for timely processing of expedited Part C authorization requests**.**

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2021	96%	96%	99%	100%
February 2021	96%	96%	100%	94%
March 2021	89%	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, one (1) health network drove the lower compliance score for paid claims timeliness during the month of March 2021. Of the ten (10) files submitted by the one (1) health network, three (3) files were deficient due to the failure to meet non-contracted clean paid claim timeliness (30 calendar day from date of claim receipt).

- Based on the overall universe of OneCare claims for CalOptima's health networks for January 2021, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 89.85% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 99.79% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

8. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
January 2021	95%	87%	96%	88%	94%	81%	83%	90%	85%	95%	97%
February 2021	99%	92%	95%	93%	95%	93%	94%	93%	98%	100%	100%
March 2021	98%	100%	93%	99%	94%	100%	89%	94%	97%	99%	100%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness during the month of March 2021. Of the thirty (30) files submitted in the aggregate by two (2) health networks, three (3) files were deficient for timeliness. The deficiency for the lower score for timeliness were due to the following:
  - Failure to meet timeframe for decision (Urgent – 72 hours)
  - Failure to meet timeframe for provider written notification (Urgent – 72 hours)

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of March 2021. Of the twenty-four (24) files submitted in the aggregate by two (2) health networks, four (4) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the health networks' failure to cite the criteria used to make the decision.

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for letter criteria during the month of March 2021. Of the sixty-four (64) files submitted in the aggregate by five (5) health networks, twenty-nine (29) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the health networks' failure to provide description of service in lay language.

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for January 2021, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 100% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Connect Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2021	93%	94%	99%	97%
February 2021	85%	94%	100%	96%
March 2021	68%	84%	99%	88%

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for Paid Claims Timeliness during the month of March 2021. Of the seven (7) health networks that submitted sixty-four (64) files in the aggregate, thirty-one **(**31) files were deficient due to the failure to meet non-contracted clean paid claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for Paid Claims Accuracy during the month of March 2021. Of the three (3) health networks that submitted thirty-seven (37) files in the aggregate, fifteen

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(15) files were deficient for accuracy. The deficiency for the lower scores for accuracy were due to the following:
- Failure to accurately process claim payment based on Medicare fee schedule
- Failure to process claims with accurate interest accrued based on CMS interest calculations

- Based on a focused review of select files, one (1) health network drove the lower compliance score for Denied Claims Timeliness during the month of March 2021. Of the one (1) health network that submitted twelve (12) files in the aggregate, one **(**1) file was deficient for timeliness. The deficiency for the lower score for timeliness was due to the failure to meet non-contracted clean paid claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for Denied Claims Accuracy during the month of March 2021. Of the four (4) health networks that submitted thirty-two (32) files in the aggregate, nine (9) files were deficient due to the failure to meet non-contracted clean paid claim timeliness (30 calendar day from date of claim receipt).

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for January 2021, CalOptima's health networks received the following overall compliance scores:
  - 90.66% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 100% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
  - 99.37% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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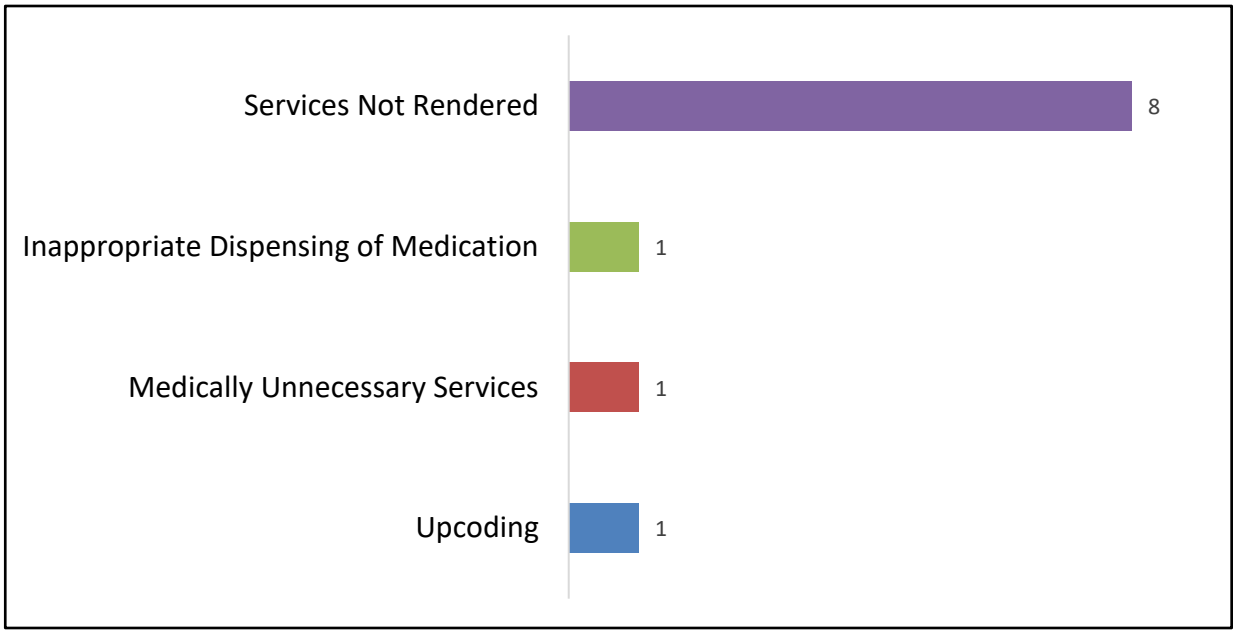
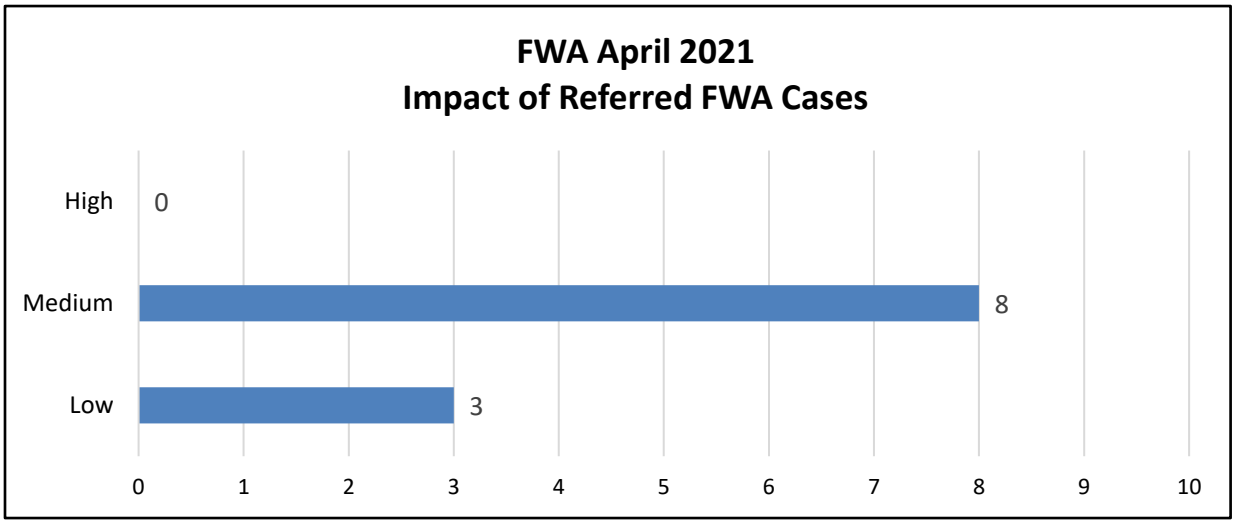
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in April 2021)





Total Number of New Cases Referred to DHCS (State)	5
Total Number of Closed Cases Referred to I-MEDIC (CMS)	6
Total Number of Referrals Reported	**11**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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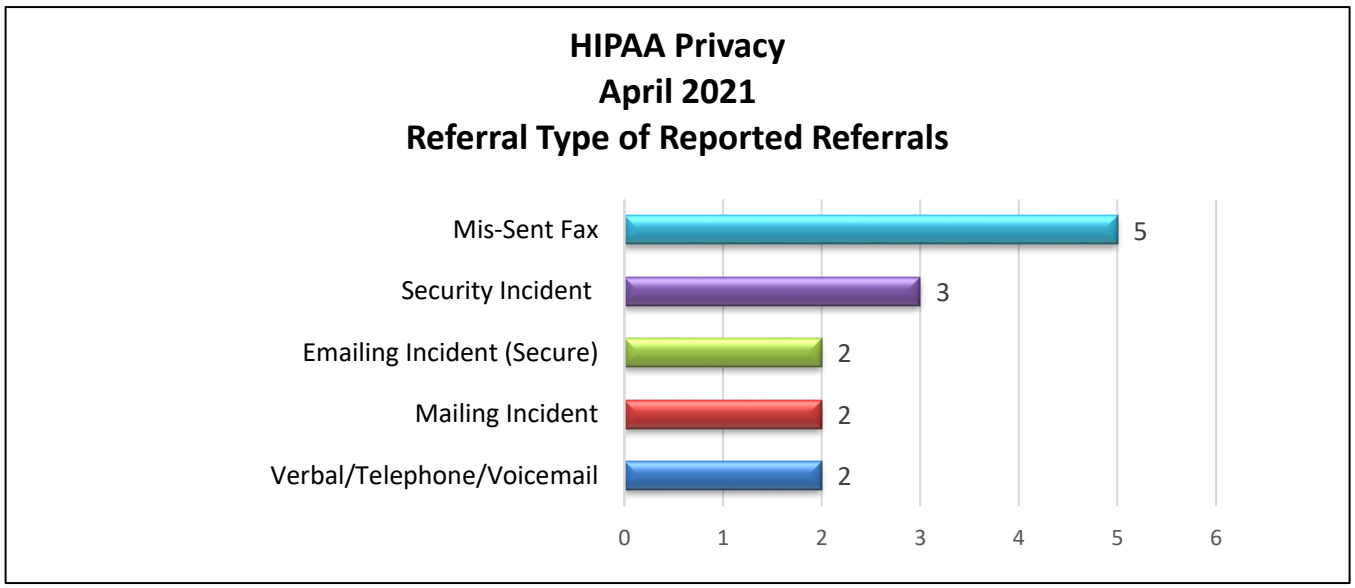
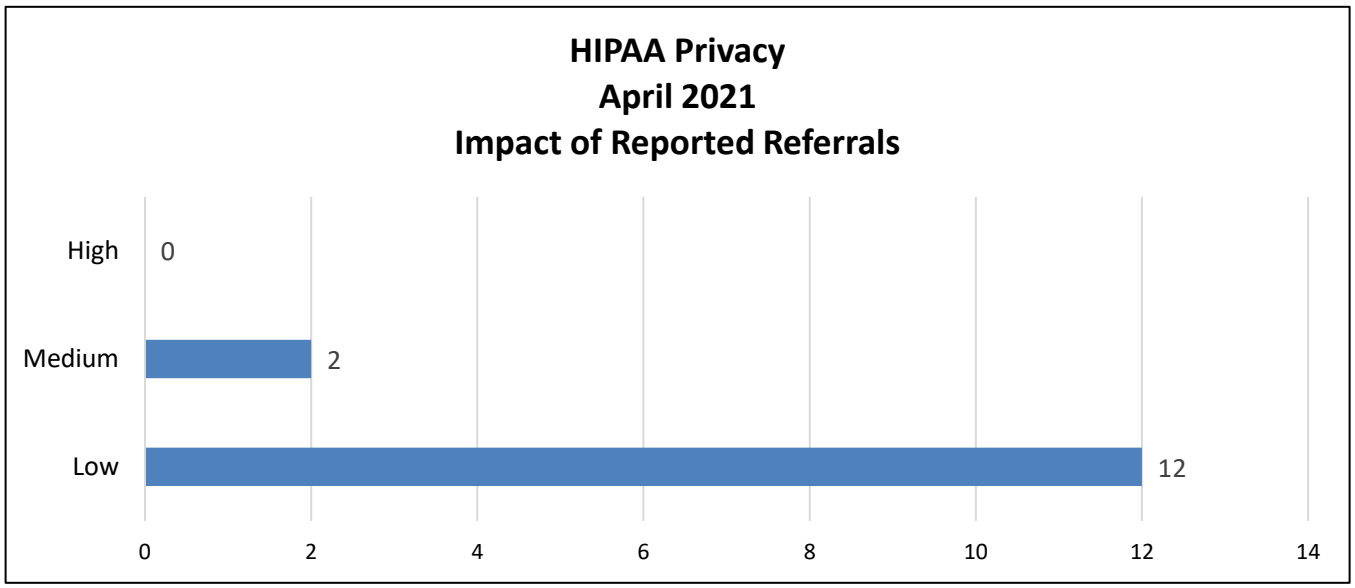
E. Privacy Update: (April 2021)





Total Number of Referrals Reported to DHCS (State)	14
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**14**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

May 13, 2021

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: May Board of Directors Report

Members of Congress returned to Washington on May 10 with a busy agenda that includes appropriations, infrastructure legislation, nominations, and legislative activity on drug pricing. This report covers developments through May 12, 2021.

FY 2022 Budget/Appropriations

Most deadlines have passed for Members to submit earmarks and other appropriations requests to the House Appropriations Committee, which will begin marking up spending bills in June with the goal of floor action in July. In addition, House Budget Committee Chair John Yarmuth (D-KY) has announced plans to take up a Fiscal Year (FY) 2022 budget resolution in June to set discretionary spending limits and facilitate the budget reconciliation process that will allow Democrats to pass President Biden's infrastructure and tax plans with a simple majority in the Senate. House appropriators are working without a full budget request from the President; the White House released a "skinny budget" outline last month, and a full budget is expected to be sent to Congress by Memorial Day. House Appropriations Chair Rosa DeLauro (D-CT) also stated that House Democrats plan to take up a supplemental appropriations measure in the coming weeks to make improvements to Capitol security.

Following the House's lead, Senate Appropriations Chair Patrick Leahy (D-VT) announced that the Committee would be accepting earmark requests for FY 2022. While Senate Republicans voted to retain the conference's earmark "ban," the rule is nonbinding and some Members are expected to submit requests.

American Families Plan

Following up on the $2.3 trillion American Jobs Plan released in March, the White House outlined a new $1.8 trillion package on April 28 that addresses child care, education, and family leave, among other issues. The proposal, known as the American Families Plan, calls for $200 billion to permanently extend the expanded premium tax credits included in the American Rescue Plan. The package also calls for investments in maternal health and veterans' health, though no specific provisions are included. Many of these details will be emerge as House committees start drafting legislation.

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In his address to a joint session of Congress, President Biden also highlighted his administration's plans to tackle "outrageous" prescription drug prices and suggested that savings from these reforms could be used to pay for an expansion of Medicare benefits and eligibility. The President did not indicate whether such proposals would be included in his infrastructure or family plans.

Prescription Drug Pricing

As new COVID-19 cases in the United States continue to decline, House and Senate committees are shifting their focus to other health care issues. On April 22, House Energy and Commerce Chair Frank Pallone (D-NJ), Ways and Means Chair Richard Neal (D-MA), and Education and Labor Chair Bobby Scott (D-VA) reintroduced the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3). The Democratic drug pricing proposal passed the House during the last Congress but failed to advance in the Senate. The wide-ranging package would establish a "fair price negotiation" program; create inflation rebates in Medicare Part B and Part D; establish an out-of-pocket maximum for Part D enrollees; and require reporting on manufacturer price increases.

On May 4, the Energy and Commerce Committee's Health Subcommittee held a hearing to examine a number of drug pricing measures, including H.R. 3, and the Education and Labor Committee's Health, Employment, Labor, and Pensions Subcommittee held a similar hearing on May 5. Republicans on both panels offered strong criticism of H.R. 3 and instead touted their own legislation, the Lower Costs, More Cures Act (H.R. 19).

Prescription drug pricing is also a priority for Senate Finance Committee Chair Ron Wyden (D-OR) and Ranking Member Chuck Grassley (R-IA), though the Committee has not yet held a hearing on the topic this year.

Surprise Billing Update

Providers and payers are anxiously awaiting the release of the first regulations on surprise medical billing, following the enactment of the No Surprises Act as part of the year-end spending package that Congress approved in December. The No Surprises Act protects patients from "balance billing" when they receive emergency care or certain other services from an out-of-network provider. The measure also calls for the creation of arbitration process for disputes between providers and payers. Most of the provisions take effect in January 1, 2022, and the law's first major regulatory deadlines are in July 2021.

Members and stakeholders are already lobbying to shape the regulations. On April 29, Sens. Maggie Hassan (D-NH) and Bill Cassidy (R-LA) sent a letter to the Department of Health and

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Human Services (HHS), the Department of Labor, and Treasury Department, outlining their recommendations for implementing the law's provisions related to arbitration, transparency, and consumer protection. Reps. Larry Bucshon (R-IN) and Raul Ruiz (D-CA) penned a similar letter on May 5, urging the administration to ensure that any regulations or guidance issued treats all parties fairly in the arbitration process.

Administration Nominations

Chiquita Brooks-LaSure's nomination for Centers for Medicare and Medicaid Services (CMS) Administrator was temporarily stalled on April 22 after a 14-14 confirmation vote in the Senate Finance Committee. Republicans objected to the nomination after Sen. John Cornyn (R-TX) said he would place a procedural hold on the nomination due to his concerns about CMS' recent decision to rescind Texas' Medicaid 1115 waiver. Her nomination advanced on May 12, however, following a procedural vote in the full Senate on Majority Leader Schumer's discharge petition to bring the nomination to the floor. Brooks-LaSure is expected to be confirmed later this month.

On May 11, the Senate voted 61-37 to confirm Andrea Palm as Deputy Secretary of Health and Human Services.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

May 14, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

The big news in the California Capitol is the release of the Governor's May Revision to the 2021-22 State Budget that he proposed to the Legislature in January. This revised budget document is supposed to reflect updated tax revenues and spending trends to better enable the Legislature to pass a balanced budget on June 15 for the fiscal year that will begin on July 1.

Passing and enacting the State Budget is the most important function the Legislature performs as it dictates how the state spends approximately $267 billion in total revenue. As such, Capitol stakeholders eagerly await the release of the May Revise, as that is when the Legislature starts making final decisions on spending priorities after spending the previous 4 months holding committee hearings and crafting their own budget based on their priorities. At least that is how textbooks would describe the process.

In reality, the Governor and Legislature are constrained by Constitutional mandates, bonds funds, special funds, court rulings and federal funds that limit the discretion on how to spend money in the state budget. When revenues are down, there is very little discretion. However, when revenues are up, there is much more discretion. This brings us to this year's May Revise – revenues are up. Way up.

2020-21 Unexpected Budget Surplus
When the COVID-19 pandemic hit in 2020, the service sector and non-essential businesses closed, and unemployment skyrocketed. State budget analysts expected the worst and forecast a $54 billion deficit in the current fiscal year. Based on that projection, the Legislature and Governor adopted a conservative budget with little or no increases in spending. However, the estimate was way off, as essential businesses continued to operate, many professionals were able to work from home, and most importantly, those with a lot of wealth continued to accumulate wealth through the stock market. California's income tax revenues are very reliant, in fact too reliant, on taxes generated from the capital gains on the sale of stocks. In January, the Governor said the state would end the fiscal year with $15 billion surplus. But even that projection was way off.

Unprecedented Surplus
The Governor's May Revise projects a **$75 billion surplus** of revenue above projected spending for 2021-22. This is a $129 billion swing in forecasting from a year ago. It is an unprecedented surplus that is larger than the entire state budgets of all but a few states, and the swing in forecasted revenue from the previous year is almost as large as

California's entire General Fund spending. The non-partisan Legislative Analyst Office termed the surplus as being "once-in-a-generation magnitude" and it is coupled with $26 billion in federal America Rescue Plan funding that does not have to be spent in the next fiscal year. With over $100 billion in new revenues, the Governor and Legislature have considerable ability to deliver projects and services to Californians.

Governor Newsom and the California Comeback Tour
The Governor this week embarked on a week-long rollout of the May Revise, which he has promoted as the California Comeback Plan. With a recall election looming in the Fall, the Governor has made what can be fairly characterized as campaign stops around the state to make major announcements on how he intends to spend the surplus.

Monday – Taxpayer Relief
The Governor announced his California Comeback Plan and revealed that there is a total $100 billion surplus to spend at a press conference in Oakland. At this press conference he pledged that his May Revise would include:

- **$12 billion in direct payments to all taxpayers who make less than $75,000 per year.**
- **$5.2 billion to low-income renters to cover back rent due to the pandemic.**
- **$2 billion to help Californians pay overdue water and utility bills.**

Tuesday – Homelessness and Housing
The Governor held a press conference at a Project HomeKey location in San Diego to announce his plan to use part of the $100 billion surplus to address the homelessness crisis in California. Key to this effort is an expansion of Project HomeKey and Project RoomKey which are state-funded efforts to acquire hotels, motels, and rooms to provide permanent and temporary housing for homeless individuals and families. Specifically, the Governor announced:

$12 billion to address homelessness:
- **$7 billion to expand Project HomeKey**
- **$3.5 billion for rental support and shelter and housing assistance**
- **$1.5 billion to clean up public encampments and open spaces**

Wednesday – Education
The Governor held a press conference in Castroville to announce increased funding for the state's public education system. Specifically:

$20 billion total investment in education:
- **$15 billion for K-12 public schools**
- **$2 billion for college savings accounts**
- **$3.4 billion for universal pre-kindergarten**

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Thursday – Business Relief
The Governor addressed the California Chamber of Commerce at its annual Host Breakfast to announce additional funding for existing targeted business assistance programs. This includes:

- **$1.5 billion in COVID relief grants to small business**
- **$6.2 billion to conform California tax code to the federal government to make Payroll Protection Program loans not count as income to those businesses that utilized the loans.**
- **Hundreds of millions of dollars in various targeted tax credits, grants and loans.**

Friday – The Big Reveal – May Revise -- $267 billion in total spending
The Governor held a press conference in Sacramento to release the details of the whole May Revise. The Governor used this occasion to re-emphasize and augment the spending priorities that he proposed in his original January Budget. After a nearly three-hour press conference, the Governor put the details of Budget online for review.

We will do a deeper examination of the May Revision and its impact over the next few days and update you as appropriate.

Governor Recall Update
As noted above, the timing and method of releasing the May Revise and all the spending and projects it promises for Californians is certainly related to the pending recall election that will likely be scheduled for the ballot in late October. After months of public criticisms related to the closure of schools, business, and social activity, the Governor is clearly utilizing the budget windfall to be in the public eye and restore confidence in his governorship.

With the effects of the pandemic winding down with businesses and schools reopening, the Governor's is indeed gaining goodwill with voters. It should be expected the budget news will continue to improve his standing in the public eye.

On May 11, the UC Berkeley Institute of Governmental Studies released a poll from the first week of May showing that support for recalling the Governor remains stagnant at 36 percent, while those who are opposed to recalling the Governor has grown to 49 percent.

In the separate question of who should replace the Governor should he be recalled, the poll showed that none of the replacement candidates generate enthusiasm with voters, with none garnering more than 22 percent of support. Caitlyn Jenner has the least support at 6 percent with both John Cox and Kevin Faulconer garnering 22 percent.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 454 Rodriguez	**Provider Supplemental Payments:** Would allow the Department of Managed Health Care (DMHC) to require health plans to provide supplemental payments and/or nonmonetary support to any severely impacted providers during and for 60 days after a public health emergency or disaster declaration. DMHC may require health plans to provide rate increases, one-time payments, personal protective equipment, and/or other equipment and business expenses to ensure the continued operation of the practice, but no more than the total payment amount that the plan would have paid in an average year.	**05/04/2021** Re-referred to Assembly Appropriations Committee **04/27/2021** Passed Assembly Health Committee **02/08/2021** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose
SB 510 Pan	**Disease Testing and Vaccination Coverage:** Would require a health plan to cover COVID-19 testing and vaccinations provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements, during a public health emergency. This bill would also apply these requirements to any future diseases causing a public health emergency.	**04/12/2021** Re-referred to Senate Appropriations Committee **04/07/2021** Passed Senate Health Committee **02/17/2021** Introduced	CalOptima: Watch CAHP: Oppose Unless Amended
SB 242 Newman	**Provider Reimbursement for Medically Necessary Equipment:** Would allow physicians and dental providers to be reimbursed for medically necessary business expenses, in compliance with a public health order, to treat and reduce the spread of COVID-19 or other infectious diseases in the workplace during a public health emergency. Reimbursable expenses would include personal protective equipment, infection control supplies, testing supplies and processing, and related information technology expenses.	**04/13/2021** Re-referred to Senate Appropriations Committee **03/10/2021** Passed Senate Health Committee **01/21/2021** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 764 Wyden	**Crisis Assistance Helping Out on the Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide community-based mobile crisis intervention services under a State Plan Amendment or waiver. Would provide states a 95% FMAP for such services.	**03/16/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 563 Berman	**Office of School-Based Health Programs:** Would establish the Office of School-Based Health Programs within the California Department of Education (CDE), no later than July 1, 2022, to administer current health programs, including the LEA Medi-Cal Billing Option Program, and Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) services. Would also require the CDE to coordinate with DHCS and LEAs to increase access to and expand the scope of school-based Medi-Cal programs.	**04/13/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **03/24/2021** Passed Assembly Education Committee **02/11/2021** Introduced	CalOptima: Watch
AB 586 O'Donnell	**School Health Demonstration Project:** Would establish the School Health Demonstration Project, as a two-year program, to expand comprehensive physical and mental health access to students. The CDE would provide support, technical assistance and $500,000 in annual grants to LEAs to participate in additional Medi-Cal funding opportunities and build partnerships with Medi-Cal managed care plans (MCPs), county mental health plans (MHPs) and private health plans.	**04/19/2021** Re-referred to Assembly Appropriations Committee **04/13/2021** Passed Assembly Health Committee **04/07/2021** Passed Assembly Education Committee **02/11/2021** Introduced	CalOptima: Watch
AB 822 Rodriguez	**Emergency Psychiatric Observations:** Would add observation services for a psychiatric emergency medical condition as a covered Medi-Cal specialty mental health benefit. Medi-Cal MCPs would be required to pay when the suspected condition is later determined not to be a psychiatric emergency.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/16/2021** Introduced	CalOptima: Watch LHPC: Oppose Unless Amended
SB 221 Wiener	**Timely Access to Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment—in alignment with the current time frame for the initial appointment.	**03/22/2021** Re-referred to Senate Appropriations Committee **03/17/2021** Passed Senate Health Committee **01/13/2021** Introduced	CalOptima: Watch CAHP: Oppose

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 293 Limon	**Standardized Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) Forms:** Would require DHCS to develop standardized forms for specialty mental health services provided under EPSDT after January 1, 2022. Consistent with the CalAIM proposal, the forms would address medical necessity criteria, screening tools and transition of care tools, which would impact coordination and referrals with Medi-Cal MCPs.	**03/18/2021** Re-referred to Senate Appropriations Committee **03/17/2021** Passed Senate Health Committee **02/01/2021** Introduced	CalOptima: Watch
SB 562 Portantino	**Autism Spectrum Disorder (ASD) Treatment:** Would revise and expand the definitions of those providing care and support to individuals with ASD and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental, Individual-differences and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, would be authorized to be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services will not been denied or limited if a parent or caregiver is unable to participate.	**04/21/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/06/2021** Passed Senate Human Services Committee **02/18/2021** Introduced	CalOptima: Watch
SB 773 Roth	**Medi-Cal Incentive Payments for School-Based Behavioral Health:** Would require DHCS to make incentive payments to Medi-Cal MCPs for the 2022–24 rating period if plans increase access to preventive and behavioral health services for K–12 students through targeted interventions by school-based behavioral health providers. Of note, Gov. Newsom included $400 million of one-time funding in the proposed state budget for this initiative.	**04/14/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **02/19/2021** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 875 Wood	**CalAIM Proposal: County Inmate Release Coordination:** No later than January 1, 2023, would require Medi-Cal MCPs to coordinate with county jails, juvenile facilities and county MHPs to provide continued behavioral health services to former inmates who received the same services while incarcerated.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/17/2021** Introduced	CalOptima: Watch
AB 942 Wood	**CalAIM Proposal: Behavioral Health:** Would require DHCS to implement alternate criteria for medical necessity regarding behavioral health services, as well as mandatory screening and transition of care tools for Medi-Cal behavioral health benefits no sooner than January 1, 2022. Additionally, as of January 1, 2027, the bill would require a county/counties to administer behavioral health benefits under a single Medi-Cal behavioral health delivery system contract.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/17/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1132 Wood	**CalAIM Proposal: Standardized MCP Benefits and Dual Eligible Special Needs Plan (D-SNP) Transition:** Would require Medi-Cal MCPs to operate a D-SNP in Coordinated Care Initiative (CCI) counties by January 1, 2023, and in non-CCI counties by January 1, 2025. Would also standardize the benefits provided by Medi-Cal MCPs statewide, including the carve-out of the Multipurpose Senior Services Program (MSSP) and the carve-in of organ transplants by January 1, 2022, and the carve-in of institutional long-term care services by January 1, 2023.	**05/03/2021** Re-referred to Assembly Appropriations Committee **04/27/2021** Passed Assembly Health Committee **02/18/2021** Introduced	CalOptima: Watch
SB 256 Pan	**CalAIM Proposal:** Would authorize DHCS to implement the CalAIM proposal, including the following provisions: ■ Enhanced Care Management ■ ILOS ■ Incentive payments to Medi-Cal MCPs ■ Mandatory managed care enrollment populations ■ Population Health Management program ■ Regional capitation rates	**04/28/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **01/26/2021** Introduced	CalOptima: Watch
SB 279 Pan	**CalAIM Proposal:** Would terminate the Health Homes Program on January 1, 2022, require all MCPs and health plan subcontractors to become accredited by the National Committee for Quality Assurance by January 1, 2026, and implement the State Plan Dental Improvement Program.	**04/28/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **01/29/2021** Introduced	CalOptima: Watch
RN 21 08858 Trailer Bill	**CalAIM Proposal:** Would codify various provisions of the CalAIM Proposal as revised by DHCS on January 8, 2021, for which implementation requires changes in state law.	**02/01/2021** Published on the Department of Finance website	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit.	**01/04/2021** Introduced; referred to House Committees on Energy and Commerce, Ways and Means and Armed Services	CalOptima: Watch
H.R. 1118 Dingell	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations.	**02/18/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 114 Maienschein	**Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit for any beneficiary who is at least one year of age and is receiving inpatient services in an intensive care unit. The benefit would include individual sequencing, trio sequencing for one or more parent and their baby, and ultra-rapid sequencing.	**04/13/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **12/17/2020** Introduced	CalOptima: Watch
AB 342 Gipson	**Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for a colorectal cancer screening and laboratory test recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, would prohibit health plans from imposing cost sharing on colonoscopies for those between 50 and 75 years of age. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider.	**03/26/2021** Re-referred to Assembly Appropriations Committee **03/23/2021** Passed Assembly Health Committee **01/28/2021** Introduced	CalOptima: Watch
SB 245 Gonzalez	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2022. Likewise, a health plan may not require a prior authorization or impose an annual or lifetime limit on such coverage.	**04/12/2021** Re-referred to Senate Appropriations Committee **04/07/2021** Passed Senate Health Committee **01/22/2021** Introduced	CalOptima: Watch CAHP: Oppose
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home STD test kits and any associated laboratory fees. Would also authorize Medi-Cal reimbursement for STD-related services at the same rate as comprehensive family planning services, even when the patient is not at risk of becoming pregnant or in need of contraception	**04/19/2021** Passed Senate Business, Professions and Economic Development Committee; referred to Senate Appropriations Committee **04/07/2021** Passed Senate Health Committee **02/04/2021** Introduced	CalOptima: Watch CAHP: Oppose

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 523 Leyva	**Contraceptive Equity Act of 2021:** Effective January 1, 2022, would require health plans to provide coverage of all Food and Drug Administration-approved over-the-counter contraceptive drugs, devices, and products, including vasectomies, without a prescription and regardless of gender. Would also require coverage of related examinations, procedures, and consultations.	**05/03/2021** Re-referred to Senate Appropriations Committee **04/28/2021** Passed Senate Health Committee **04/05/2021** Passed Senate Labor, Public Employment and Retirement Committee **02/17/2021** Introduced	CalOptima: Watch
RN 21 05566 Trailer Bill	**Delayed Suspension of Medi-Cal Adult Optional Benefits:** Would delay the suspension of certain Medi-Cal adult optional benefits, which are currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Extended optional benefits include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch
RN 21 05595 Trailer Bill	**Delayed Suspension of Medi-Cal Postpartum Care Extension:** Would delay the suspension of Medi-Cal postpartum expanded eligibility, which is currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Postpartum expanded eligibility allows Medi-Cal beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. Upon the discontinuation of postpartum expanded eligibility on December 31, 2022, postpartum care would terminate 60 days after the last day of pregnancy.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

MEDI-CAL ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status.	**04/13/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **12/07/2020** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 112 Holden	**Inmate Eligibility Extension:** Would delay the termination date of Medi-Cal eligibility for non-juvenile inmates from one year of elapsed incarceration to three years of elapsed incarceration. For juvenile inmates, Medi-Cal eligibility would not be terminated until three years after their status as a juvenile has ended.	**03/26/2021** Re-referred to Assembly Appropriations Committee **03/23/2021** Passed Assembly Health Committee **12/17/2020** Introduced	CalOptima: Watch
AB 470 Carrillo	**Elimination of Asset Consideration:** Would prohibit the consideration of any assets or property in determining Medi-Cal eligibility under any aid category, subject to federal approval.	**04/14/2021** Re-referred to Assembly Appropriations Committee **04/06/2021** Passed Assembly Health Committee **02/08/2021** Introduced	CalOptima: Watch LHPC: Support
SB 56 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status.	**03/10/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **12/07/2020** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1738 Dingell	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Similar to S. 646, would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary.	**03/10/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch ACAP: Support
S. 646 Brown	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Similar to H.R. 1738, would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary.	**03/09/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch ACAP: Support
AB 1050 Gray	**Medi-Cal Beneficiary Communications Consent:** Would amend the application for Medi-Cal benefits to include a written consent to receive text messages from DHCS, county welfare departments, MCPs and providers regarding appointment reminders and outreach efforts.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/18/2021** Introduced	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1082 Waldron	**California Health Benefits Review Program (CHBRP) Extension:** Would extend current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed states legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill would also increase the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022.	**03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/18/2021** Introduced	CalOptima: Watch CAHP: Support In Concept
AB 1131 Wood	**Health Information Network (HIN):** Would establish a statewide HIN to facilitate the required exchange of patient data among all health plans, health systems, providers, hospitals, skilled nursing facilities and laboratories in California. Exchanged data would include clinical summaries, claims, encounter data, laboratory data, eligibility files, and race and ethnicity information.	**04/06/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/18/2021** Introduced	CalOptima: Watch
AB 1162 Villapadua	**Claims Processing Timeline and Prior Authorizations During Emergency:** Would shorten the timeline for health plans to process submitted claims from 30-45 days to 20 days for all health plans. Additionally, would allow DMHC to suspend health plan requirements for prior authorizations in any county where a declared state of emergency has impacted beneficiaries or providers.	**04/27/2021** Re-referred to Assembly Appropriations Committee **04/20/2021** Passed Assembly Health Committee **02/18/2021** Introduced	CalOptima: Watch CAHP: Oppose Unless Amended
AB 1355 Levine	**Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system for Medi-Cal MCPs, effective January 1, 2022. The bill would also provide every Medi-Cal beneficiary filing a grievance with access to an IMR.	**03/04/2021** Referred to Assembly Health Committee **02/19/2021** Introduced	CalOptima: Watch
SB 250 Pan	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2023, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for two years. A provider would qualify if their number of denied prior authorizations requests (which were not appealed or were lost upon appeal) are both within a certain range of the average numbers for the same specialty in the same region.	**03/17/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **01/25/2021** Introduced	CalOptima: Watch CAHP: Oppose
SB 371 Caballero	**Health Information Technology and Exchange:** Would require DHCS to apply for federal funding from the American Rescue Plan Act of 2021 or the Medicaid Information Technology Architecture program to create a unified data exchange between the state government, health records systems, other data exchange networks and health care providers, including for the Medi-Cal program. Funds would also be used to provide grants and technical support to small provider practices, community health centers and safety net hospitals to expand the use of health information technology and connect to exchanges.	**03/24/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **02/10/2021** Introduced	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 08473 Trailer Bill	**Delayed Proposition 56 Suspensions:** Would delay the suspension of certain value-based payment (VBP) programs authorized under Proposition 56, which are currently set to expire on July 1, 2021. For VBP programs aimed at improving behavioral health integration, DHCS would suspend payments after spending a total of $95 million. For all other VBP programs, DHCS would suspend payments on July 1, 2022.	**02/04/2021** Published on the Department of Finance website	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1868 Yarmuth	**Extension of Medicare Sequestration Moratorium:** Extends the moratorium on automatic, across-the-board 2% spending cuts to Medicare payments. The moratorium, which was set to expire on March 31, 2021, now ends on December 31, 2021.	**04/14/2021** Signed into law **04/13/2021** Passed the House **03/25/2021** Passed the Senate **03/12/2021** Introduced	CalOptima: Watch
S. 1162 Casey	**Program for All-Inclusive Care for the Elderly (PACE) Plus Act:** Would increase the number of PACE programs nationally by making it easier for States to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility.	**04/15/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch NPA: Support
AB 523 Nazarian	**PACE Flexibilities:** Would permanently extend most flexibilities granted to PACE organizations during the COVID-19 public health emergency. This includes flexibilities relating to telehealth services, verbal agreements followed with in-person signatures, Adult Day Health Center home-based services and discharge planning.	**05/04/2021** Re-referred to Assembly Appropriations Committee **04/27/2021** Passed Assembly Health Committee **04/06/2021** Passed Assembly Aging and Long-Term Care Committee **02/10/2021** Introduced	CalOptima: Watch CalPACE: Support/ Sponsor

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 540 Petrie-Norris	**PACE Enrollment Process:** Would seek to increase enrollment into PACE organizations by: ■ Listing PACE as a Medi-Cal/Medicare plan choice in areas where a PACE center is available and there is more than one MCP ■ Delaying mandatory or passive enrollment into MCPs by up to 60 days for new Medi-Cal beneficiaries who express interest in being assessed for PACE ■ Requiring DHCS to establish an auto-referral program for those who may be eligible for PACE upon Medi-Cal enrollment based on age, residence, and prior use of services	**04/28/2021** Re-referred to Assembly Appropriations Committee **04/20/2021** Passed Assembly Health Committee **04/06/2021** Passed Assembly Aging and Long-Term Care Committee **02/10/2021** Introduced	CalOptima: Watch CalPACE: Support/ Sponsor
AB 1083 Nazarian	**Senior Affordable Housing Nursing Pilot Program:** Would require the California Department of Aging to establish and administer the Housing Plus Services Nursing Pilot Program in the counties of Los Angeles, Orange, Riverside, Sacramento and Sonoma. The program would provide grant funds to qualified nonprofit organizations that specialize in resident services for the purpose of hiring one full-time registered nurse to work at three senior citizen housing developments in each county. The registered nurse would be required to provide health education, navigation, coaching and care to residents.	**04/20/2021** Passed Assembly Aging and Long-Term Care Committee; referred to Assembly Appropriations Committee **02/18/2021** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 671 Wood	**Disease Management Payment for Specialty Drugs:** Would require DHCS to provide a supplemental disease management payment to contracted pharmacies for dispensing specialty drugs to ensure beneficiary access.	**03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/12/2021** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 882 Gray	**Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program:** Effective January 1, 2022, would restrict eligibility for loan payment assistance under the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which is currently available to recently graduated physicians and dentists who serve Medi-Cal beneficiaries, to only those who practice in provider shortage areas and whose patients include at least 30% Medi-Cal beneficiaries. Would indefinitely extend the program beyond its current termination date of January 1, 2026.	**04/15/2021** Re-referred to Assembly Appropriations Committee **04/06/2021** Passed Assembly Health Committee **02/17/2021** Introduced	CalOptima: Watch LHPC: Oppose Unless Amended
SB 365 Caballero	**Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would allow a provider-to-provider e-consult service to be reimbursable by Medi-Cal. Would require the providers to be enrolled in Medi-Cal, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The e-consult may include assessing health records, providing feedback and/or recommending a further course of action.	**05/04/2021** Re-referred to Senate Appropriations Committee **03/24/2021** Passed Senate Health Committee **02/10/2021** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 316 Eggman	**FQHC Reimbursement:** Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that does not allow an FQHC to be reimbursed for mental or dental and physical health visits on the same day; a patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit (through the member's primary care provider) and a mental health or dental visit as two separate visits, regardless of whether the visits were at the same location on the same day. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**03/10/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **02/04/2021** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

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SOCIAL DETERMINANTS OF HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 71 **Rivas, Luz**	**Bring California Home Act:** Would create the Bring California Home Fund in the State Treasury to fund a statewide homelessness solutions program. Would authorize the Homeless Coordinating and Financing Council to administer the funds to applicants, including counties and large cities, for the purpose of reducing the number of individuals experiencing homelessness. Eligible uses of funding would include rental assistance, landlord incentives, housing navigation services, moving support, operating costs of affordable supportive and transitional housing projects, and the board and care of individuals with complex needs at licensed residential facilities.	**05/04/2021** Re-referred to Assembly Appropriations Committee **04/29/2021** Passed Assembly Housing and Community Development Committee **04/19/2021** Passed Assembly Revenue and Taxation Committee **12/07/2020** Introduced	CalOptima: Watch
AB 369 **Kamlager**	**Presumptive Eligibility and Street Medicine Payment:** Would apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Would allow any Medi-Cal provider to determine presumptive eligibility and issue a temporary Medi-Cal card to such individuals. Would also allow Medi-Cal providers to receive reimbursement for any covered Medi-Cal benefit delivered to a homeless individual outside of a medical facility, including primary, specialist and laboratory services, without a referral or prior authorization. Finally, would add a field on the Medi-Cal application form to indicate homelessness.	**04/26/2021** Re-referred to Assembly Appropriations Committee **04/20/2021** Passed Assembly Health Committee **02/01/2021** Introduced	CalOptima: Watch
SB 17 **Pan**	**Office of Racial Equity:** Effective until January 1, 2029, would establish the independent Office of Racial Equity to develop a Racial Equity Framework containing guidelines and strategies for advancing racial equity across the state government by January 1, 2023. Each state agency, including DHCS, would be required to implement a Racial Equity Plan by July 1, 2023, in alignment with the goals of the framework, and the office and each agency would prepare annual reports outlining progress toward achieving those goals.	**04/15/2021** Re-referred to Senate Appropriations Committee **04/13/2021** Passed Senate Judiciary Committee **03/23/2021** Passed Senate Governmental Organization Committee **12/07/2020** Introduced	CalOptima: Watch

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TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would permit the U.S. Secretary of Health and Human Services to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions.	**01/19/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch
H.R. 2166 Sewell	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Similar to S. 150, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency.	**03/23/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch NPA: Support
S. 150 Cortez Masto	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Similar to H.R. 2166, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 public health emergency.	**02/02/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch NPA: Support
AB 32 Aguiar-Curry	**Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal MCPs, including County Organized Health Systems, to reimburse their contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal MCP, such as contracted health networks. Likewise, clinics must be reimbursed by Medi-Cal for telehealth services at the same rate as in-person services. Would also allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services. Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **12/07/2020** Introduced	CalOptima: Watch
AB 935 Maienschein	**Behavioral Health Telehealth Consultation Program:** Would create a provider-to-provider telehealth consultation program for use when assessing mental health and/or providing mental health treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2022. Would permit telehealth services to be conducted by video or audio-only calls. Additionally, would require the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would require access to a psychiatrist when deemed appropriate or requested by the treating provider.	**04/27/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/17/2021** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose Unless Amended

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 08394 Trailer Bill	**Medi-Cal Telehealth Proposal:** Would modify, extend or expand certain telehealth flexibilities adopted by DHCS during the COVID-19 pandemic to be incorporated into permanent law. Would allow FQHCs and RHCs to establish a patient within its federal designated service area through audio-visual telehealth. However, health care providers would be prohibited from establishing a patient through audio-only telehealth or other non-audio-visual telehealth modalities. Would require DHCS to specify the Medi-Cal-covered health care benefits that may be delivered through telehealth services. DHCS and Medi-Cal MCPs would be required to reimburse audio-visual telehealth services at the same rate as in-person services, while audio-only, remote patient monitoring and other modalities may be reimbursed at different rates. Additionally, would allow Medi-Cal MCPs to include telehealth services when determining compliance with network adequacy standards without the use of alternative access standard requests.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

YOUTH SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**CARING for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs.	**01/04/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch
S. 453 Casey	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency.	**02/25/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch
AB 393 Reyes	**Early Childhood Development Act of 2020:** Effective immediately, would require the California Department of Social Services (CDSS) to conduct an evaluation of emergency childhood services provided during the COVID-19 public health emergency, including the following: ■ Availability of crisis childcare services ■ Availability of COVID-19 testing and personal protective equipment ■ Vaccination prioritization and distribution ■ Cleaning of childcare centers ■ Payment to family childcare homes during state-mandated closures ■ Foster care programs CDSS would be required to submit its findings and associated recommendations to the State Legislature by October 1, 2021.	**04/21/2021** Passed Assembly Human Services Committee; referred to Assembly Appropriations Committee **02/02/2021** Introduced	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 428 Hurtado	**Adverse Childhood Experiences Screenings (ACEs):** Would require a health plan to provide coverage for ACEs.	**04/21/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **02/12/2021** Introduced	CalOptima: Watch
SB 682 Rubio	**Childhood Chronic Health Conditions:** Would require CHHS, the Governor's office and other departments to develop and implement a plan that reduces racial disparities in children with chronic health conditions by 50% by 2030. Chronic conditions may include asthma, diabetes, depression and vaping-related diseases.	**04/12/2021** Re-referred to Senate Appropriations Committee **04/07/2021** Passed Senate Health Committee **02/19/2021** Introduced	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by a policy committee in their originating house. These are now considered two-year bills and are eligible for reconsideration in 2022:

- AB 58 (Salas)
- AB 552 (Quirk-Silva)
- AB 685 (Maienschein)
- AB 797 (Wicks)
- AB 862 (Chen)
- AB 1107 (Boerner Horvath)
- AB 1117 (Wicks)
- AB 1160 (Rubio)
- AB 1254 (Gipson)
- AB 1372 (Muratsuchi)
- AB 1400 (Kalra, Lee, Santiago)
- SB 508 (Stern)

*Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: May 10, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
June 3, 2021

CalOptima Community Outreach Summary — May and June 2021

Background
CalOptima is committed to serving our community by sharing information with current and potential members, and strengthening relationships with our community partners. CalOptima accomplishes this by participating in community coalitions, collaborative meetings and advisory groups, supporting our community partners' public activities and sharing information with current and potential members.

CalOptima's participation in public activities supports:

- Member interaction/enrollment in a CalOptima program
- Branding that promotes community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima is following all local, state and federal guidelines to help mitigate the spread of COVID-19 and, as such, is not attending in-person meetings or public activities. CalOptima staff continues to participate in public activities via virtual meetings and events, providing educational materials on CalOptima's programs and, if criteria are met, providing financial support and/or CalOptima-branded items.

CalOptima Highlights
CalOptima hosted a virtual Community Alliances Forum on Tuesday, May 11, 2021, from 9 a.m.–11 a.m. The event topic was "COVID-19 Update, Vaccines and Addressing Barriers for Health Equity." The forum was open to community-based organizations, health care providers, policy makers, individuals and organizations serving CalOptima members and staff.

The goal of the forum was to share information about CalOptima's role in improving access to COVID-19 vaccines for members and the various initiatives taking place in Orange County to address health equity during the pandemic. Attendees learned about "Project Independence," the county's initiative to partner with the Orange County Fire Authority and community organizations to administer COVID-19 vaccinations to eligible residents throughout the county. The panel of speakers included Dr. Regina Chinsio-Kwong, Deputy Health Officer at Orange County Health Care Agency, Dr. Emily Fonda, CalOptima's Chief Medical Officer, Isabel Becerra, Chief Executive Officer at the Coalition of Orange County Community Health Centers and Vice Chair of CalOptima's Board of Directors and Ellen Ahn, Executive Director at Korean Community Service Health Center. The event provided an opportunity for our community partners to learn about collaborative efforts and innovative strategies implemented to support vaccines and health equity during the pandemic.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **(657) 235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
As of May 9, 2021, CalOptima planned to participate in, organize or convene 65 public activities in May and June. For May, these include 38 public activities: 23 virtual community/collaborative meetings; 2 drive-thru and 6 virtual community events; 5 community-based organization presentation; 1 Community Alliance Forum; and 1 CalOptima Health Network Forum.

For June, these include 27 public activities: 21 virtual community/collaborative meetings; 1 virtual community event; 3 community-based organization presentations; 1 Cafecito; and 1 CalOptima Health Network Forum.

Below are more details about CalOptima's expected participation in these community and CalOptima-hosted events:

May 2021			
Date/Time	**Event Title/Location**	**Expected Staff/Volunteer/Financial Participation**	**Event Type/Audience**
5/1–5/31 8 a.m. and at 6 p.m.	**South County Senior Summit hosted by Age Well Senior Services and partners†** Virtual	1 staff member presented Sponsorship fee: $10,000 included a 10-minute speaking opportunity featured CalOptima COVID-19 animated "explainer" video, placement of CalOptima's logo on all event marketing and direct mailers (150,000+ oversized postcards mailed to South County households and 200,000+ digital fliers to South County residents); and recognition of sponsorship during pre-recorded event	• Health/resource fair • Open to the public
5/1 9 a.m.–12:00 p.m.	**Finish STRONG Drive–Thru hosted by MacArthur Fundamental School†** 600 W. Alton Ave., Santa Ana	No staff attended Shared education materials and CalOptima branded items	• Health/resource fair • Open to the public
5/4 5:30 p.m.–6:30 p.m.	**CalOptima Medi-Cal Presentation for Santa Ana Unified School District** Virtual	1 staff member presented	• Community-based organization presentation • Open to parents
5/5 9 a.m.–12:00 p.m.	**Drive-thru Senior Health and Wellness Fair hosted by City of La Habra†** Our Lady of Guadalupe Church 900 W. La Habra Blvd, La Habra	No staff attended Shared education materials and OCC and PACE branded items	• Health/resource fair • Open to the public
5/6 10 a.m.–12:30 p.m.	**OC Youth Service Providers Consortium hosted by Laura's House and partners†** Virtual	3+ staff members attended	• Conference • Open to health and human service providers; registration required
5/11 10 a.m.–11 a.m.	**CalOptima Medi-Cal Presentation for Thomas House Family Shelters' Staff** Virtual	1 staff member presented	• Community-based organization presentation • Open to service providers
5/11 9 a.m.–11 a.m.	**Community Alliances Forum —COVID-19 Update, Vaccines and Addressing Barriers for Health Equity*** Virtual	40+ staff members attended CalOptima presented	• Forum • Open to health and human service providers
5/12 1 p.m.–2 p.m.	**CalOptima Medi-Cal Presentation for Orange County Asian Pacific Islander Community Alliance** Virtual	1 staff member presented	• Community-based organization presentation • Open to service providers
5/13 9 a.m.–6 p.m.	**Collaborative Mental Health Conference: Hope in the Time of COVID-19 — Feeling is Healing Virtual Resource Fair hosted by Priority Center and partners†** Virtual	1 staff member presented	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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5/14 8 a.m.–9 a.m.	**CalOptima Medi-Cal Presentation for Franklin Elementary School** Virtual	1 staff member presented	• Community-based organization presentation • Open to staff and parents
5/19–5/20 8:30 a.m.–1 p.m.	**Annual Conference hosted by Families and Communities Together of Orange County†** Virtual	5+ staff members attended Sponsorship fee: $1,000 included recognition as a sponsor during the event; 5 conference admissions; and opportunity to share resources during event	• Conference • Open to health and human service providers; registration required
5/20 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	10+ staff members attended	• Forum • Open to health and human service providers
5/20 5:30 p.m.–6:30 p.m.	**CalOptima Medi-Cal Presentation for Thomas House Family Shelters' Members** Virtual	1 staff member presented	• Community-based organization presentation • Open to staff and parents
5/20 10 a.m.–11:30 a.m.	**Orange County Virtual Resource Fair and Expo hosted by Aurrera Health†** Virtual	2+ staff members attended CalOptima presented	• Health/resource fair • Open to the public
5/25–5/27 8 a.m.–1:30 p.m.	**Annual Virtual Health Literacy Conference hosted by Institute for Healthcare Advancement†** Virtual	2+ staff members attended Sponsorship fee: $1,000 included a virtual exhibit booth; visual acknowledgment of CalOptima's support during opening and closing sessions; CalOptima-branded item in the conference digital tote bag; one-time e-blast to pre-registration list; placement of CalOptima logo on a banner ad throughout the conference (4x) and digital tote bag	• Conference • Open to health and human service providers; registration required
June 2021			
6/8 6:30 p.m.–8 p.m.	**CalOptima Medi-Cal Presentation for Regional Center Orange County (English)** Virtual	1 staff member to present	• Community-based organization presentation • Open to the public
6/9 6:30 p.m.–8 p.m.	**CalOptima Medi-Cal Presentation for Regional Center Orange County (Spanish)** Virtual	1 staff member to present	• Community-based organization presentation • Open to the public
6/16 6:30 p.m.–8 p.m.	**CalOptima Medi-Cal Presentation for Regional Center Orange County (Vietnamese)** Virtual	1 staff member to present	• Community-based organization presentation • Open to the public
6/17 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	10+ staff members to attend	• Forum • Open to health and human service providers
6/17–6/18 8 a.m.–12:30 p.m.	**Meeting of the Minds Mental Health Conference hosted by Mental Health Association of Orange County†** Virtual	5+ staff members to attend	• Conference • Open to health and human service providers; registration required

* CalOptima Hosted
† Exhibitor/Attendee

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6/30 9 a.m.–10:30 a.m.	**Cafecito Meeting*** Virtual	3+ staff members to attend	• Steering committee meeting • Open to collaborative members

CalOptima's participation in community meetings throughout Orange County can be found at: https://www.caloptima.org/en/About/CommunityRelations/UpcomingEventsAndMeetings.aspx.

Sponsorship requests must align with CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

Endorsements
CalOptima provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsements must align with CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
23. Consider Approval of the CalOptima Fiscal Year 2021-22 Operating Budget

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2021-22 Operating Budget; and
2. Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy.

Background
The CalOptima FY 2021-22 Operating Budget provides revenues and appropriations for the period of July 1, 2021, through June 30, 2022, and includes the following budget categories:

- Medi-Cal;
- OneCare Connect;
- OneCare;
- Program for All-Inclusive Care for the Elderly (PACE);
- Multipurpose Senior Services Program (MSSP);
- Facilities; and
- Investment income.

Staff is submitting the complete budget for all lines of business for approval with assumptions based on available information to date. Pursuant to CalOptima Policies GA.3202: CalOptima Signature Authority, GA.5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure and appropriates the funds requested for the item without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to Management.

The primary revenue source is the State of California. The Governor released the revised state budget (i.e., May Revise) on May 14, 2021, that projects a $75.7 billion budget surplus. This amount combined with over $25 billion in federal relief funding supports his proposed $100 billion California Comeback Plan.

Given the positive economic outlook, the May Revise contains several new proposals that will have a direct or indirect impact on CalOptima's lines of business:

- Expansion of Medi-Cal eligibility to undocumented adults ages 60 and older, effective May 2022;
- Extension of Medi-Cal eligibility from 60 days to 12 months for most postpartum individuals effective April 1, 2022, through FY 2027-28;
- New Medi-Cal covered benefit for doula services, effective January 1, 2022;

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- Addition of community health workers as a class of Medi-Cal eligible health workers (under the supervision of a licensed, enrolled Medi-Cal provider), effective January 1, 2022; and
- Elimination of the suspensions for the Proposition 56 supplemental payment increases.

Over the next month, the State Legislature will finish budget hearings and finalize a balanced budget for passage by June 15, 2021. Staff has included budget proposals from the Governor's January Proposed Budget, but has not integrated new proposals from the May Revise in this current budget. Staff will continue to monitor budget negotiations between the Legislature and the Newsom Administration, and will return to the Board with further recommendations to the extent any additional resources are necessary beyond what was incorporated in this budget.

At its May 20, 2021, meeting, the CalOptima Finance and Audit Committee recommended that the Board approve the CalOptima FY 2021-22 Operating Budget. The proposed FY 2021-22 Consolidated CalOptima Operating Budget reflects Management's efforts to balance state funding with ensuring members continue to have access to quality health care services.

CalOptima Budget Overview

I. FY 2020-21 Consolidated Operating Budget

The FY 2021-22 Consolidated Operating Budget is a combined income and spending plan for all CalOptima programs and activities.

Table 1: FY 2021-22 Consolidated Operating Budget

	FY 2021-22 Budget
Average Monthly Enrollment	839,514
Revenue	$3,656,113,456
Medical Costs	$3,555,409,559
Administrative Expenses	$169,071,466
Operating Income/Loss	**($68,367,569)**
Investments, Net	$10,000,000
Change in Net Assets*	**($58,367,569)**
Medical Loss Ratio (MLR)	97.2%
Administrative Loss Ratio (ALR)	4.6%

* Changes in Net Assets excludes other income

Budget Assumptions

Medical Cost: Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. Historical experience included several years' worth of data to incorporate trends for both the pre- and post- COVID-19 Public Health Emergency (PHE) declaration. Staff assigned various credibility to the different time periods depending on how representative they were of future utilization. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. For newly implemented programs, staff used historical data, proxy data and industry benchmarks, where available, and checked results for reasonability.

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Administrative Expenses: FY 2020-21 was forecasted utilizing a 12-month historical run-rate to account for seasonal and cyclical spending patterns. To ensure inclusion in the budget, Staff reviewed all contract encumbrances. In addition, internal departments identified resource requirements based on changes to enrollment, regulations, and organizational needs. Staff considered:

- Salaries, Wages & Benefits for current staff, unfilled budgeted positions, and new budgeted positions;
- Professional Fees, Purchased Services, Printing & Postage and Other Operating Costs based on the needs and priorities of providing health care to members;
- Depreciation & Amortization on current assets and projected assets according to Generally Accepted Accounting Principles (GAAP); and
- Indirect Cost Allocation primarily based on revenue and adjusted where necessary.

Of note, CalOptima has several contracts for claims administration, credit balance recovery, and Social Security Income conversion that are paid on a contingency basis. The following table provides a comparison of consolidated administrative expenses for the budget with previous fiscal years.

Table 2: Comparison of Consolidated Administrative Expenses

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget	FY 2021-22 Budget vs. FY 2020-21 Forecast
Revenues	$3,840,846,316	$4,046,282,642	$3,656,113,456	($390,169,186)
Salaries, Wages & Benefits	**$92,838,068**	**$92,692,765**	**$109,536,255**	**$16,843,490**
Non-Salaries	**$49,303,806**	**$41,874,649**	**$59,535,210**	**$17,660,561**
Professional Fees	$3,681,374	$1,893,241	$6,112,300	$4,219,059
Purchased Services	$12,950,542	$11,496,218	$14,739,002	$3,242,784
Printing & Postage	$5,933,750	$3,988,943	$6,685,989	$2,697,046
Depreciation & Amortization	$6,208,308	$5,939,738	$8,386,800	$2,447,062
Other Operating Expenses/Indirect Cost Allocation, Occupancy	$20,529,832	$18,556,509	$23,611,119	$5,054,610
Total	**$142,141,873**	**$134,567,414**	**$169,071,466**	**$34,504,052**
ALR	3.7%	3.3%	4.6%	1.3%
ALR Breakdown:				
Salaries, Wages & Benefits	2.4%	2.3%	3.0%	0.7%
Non-Salaries	1.3%	1.0%	1.6%	0.6%

* Forecasted as of March 2021; Revenue excludes directed payments
Note: FY 2020-21 forecasted figures do not include unfilled open positions

Attachment B: Administrative Budget Details provides additional information regarding all administrative expenses included in the FY 2021-22 Operating Budget.

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II. Enrollment by Line of Business

The following table provides a comparison of total average enrollment for the past two (2) fiscal years with the projected enrollment for FY 2021-22.

Table 3: Total Average Enrollment by Program

Program[1]	FY 2019-20 Actual[2]	FY 2020-21 Forecast[2]	FY 2021-22 Budget[2]	% Change 22 v. 21
Medi-Cal	723,978	790,884	822,208	4.0%
OneCare Connect	14,206	14,807	15,112	2.1%
OneCare	1,460	1,638	1,782	8.8%
PACE	381	389	413	6.0%
Total	**770,024**	**807,718**	**839,514**	**3.9%**

[1]MSSP enrollment included in Medi-Cal; for FY 2021-22 Budget, includes MSSP through December 2021

III. FY 2021-22 Operating Budget by Line of Business

A. Medi-Cal Program

Through a contract with the California Department Health Care Services (DHCS), CalOptima has administered the Medi-Cal program for Orange County since October 1995. The table below illustrates the Consolidated Medi-Cal Operating Budget.

Table 4: FY 2021-22 Medi-Cal Consolidated Operating Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	724,049	783,591	822,208
Revenue	$3,469,816,350	$3,640,183,421	$3,249,878,660
Medical Costs	$3,303,225,031	$3,510,546,468	$3,172,100,893
Administrative Expenses	$118,481,381	$112,846,577	$141,428,932
Operating Income/Loss	$48,109,938	$16,790,376	($63,651,165)
MLR	95.2%	96.4%	97.6%
ALR	3.4%	3.1%	4.4%

* Forecasted as of March 2021; Revenue excludes directed payments
Change in net assets excludes net investment and other income
Note: Includes MSSP through December 2021

Medi-Cal membership is comprised of three (3) main categories: Classic, Expansion, and Whole Child Model (WCM). The following table illustrates the Medi-Cal Operating Budget by these categories.

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Table 5: FY 2021-22 Medi-Cal Operating Budget by Category

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal WCM	Total
Average Monthly Enrollment	522,154	288,895	11,159	822,208
Revenue	$1,676,092,280	$1,336,597,706	$237,188,674	$3,249,878,660
Medical Costs	$1,687,208,748	$1,258,344,010	$226,548,136	$3,172,100,893
Administrative Expenses				$141,428,932
Operating Income/Loss				($63,651,165)
MLR	100.7%	94.1%	95.5%	97.6%
ALR				4.4%

DHCS uses Category of Aid (COA) to classify Medi-Cal enrollment into cohorts of similar acuity and develops CalOptima's capitation rates based on these cohorts. The following table shows the projected average enrollment distribution by COA.

Table 6: FY 2021-22 Medi-Cal Average Enrollment Projection by COA

	FY 2020-21 Forecast*	FY 2021-22 Budget	Variance	
			Diff	%
Adult	101,224	106,382	5,157	5.1%
Child	293,057	295,119	2,062	0.7%
Seniors and Persons with Disabilities (SPD)	115,382	117,462	2,080	1.8%
Long Term Care (LTC)	3,211	3,191	(20)	(0.6%)
Medi-Cal Classic Subtotal	**512,874**	**522,154**	**9,280**	**1.8%**
Medi-Cal Expansion	267,024	288,895	21,871	8.2%
WCM	10,986	11,159	173	1.6%
TOTAL	**790,884**	**822,208**	**31,324**	**4.0%**

* Forecasted as of March 2021
Note: Figures may not add due to rounding

General Budget Assumptions – Medi-Cal
DHCS will implement several policy and program changes during FY 2021-22 that will directly impact CalOptima's revenues and medical expenses. The following initiatives have been considered in the budget:

- CalAIM implementation: Includes transition of Health Homes Program (HHP) and Whole Person Care (WPC) to Enhanced Care Management (ECM) and In Lieu of Services (ILOS), effective January 2022;
- Medi-Cal Rx carve-out: Removes prescription drug benefit anticipated for January 1, 2022, including Hepatitis C medications;
- Proposition 56 directed payments program constriction: Assumes a narrower scope and continuation of program through June 30, 2022, as proposed in the Governor's January Budget; and

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- MSSP Program carve-out: Effective January 1, 2022.

Enrollment: Enrollment projections are based on actual data through March 2021 and trended through June 2022. Because of the effects on personal income from the COVID-19 pandemic, the budget assumes an increase in Temporary Assistance for Needy Families (TANF) Adult and the Medi-Cal Expansion populations. With the anticipated end date of the PHE on January 1, 2022, DHCS is planning to resume normal Medi-Cal eligibility activity, including member redeterminations. These activities will have a direct impact on CalOptima's enrollment.

Revenue: The budget includes final Calendar Year (CY) 2021 rates (received in December 2020) for the period of July 1, 2021, through December 31, 2021. Staff anticipates receipt of CY 2022 draft rates in October 2021, inclusive of the increase in the underwriting gain of 0.5%. As such, Staff has forecasted capitation rates for the period of January 1, 2022, through June 30, 2022, based on available information to date.

Medical Cost: The budget anticipates the following benefits will primarily drive trends for FY 2021-22:

- Increase in unit cost for Hospital Inpatient services, Hospital Outpatient (non-Rx) services, Skilled Nursing Facility services, and Mental Health services;
- Increase in utilization for Hospital Outpatient Surgery and Non-Medical Transportation (NMT); and
- Maintenance of increased Pay for Value (P4V) program funding from prior year budget.

Medi-Cal Classic
Classic Enrollment: The budget projects a 1.8% increase in total member months.

Classic Revenue: The budget estimates that base rates effective January 1, 2022 will be increased by an additional 2.0% to account for anticipated trends as reflected in the annual Rate Development Template (RDT) submission, as well as the communicated increase in the underwriting gain of 0.5%.

Classic Medical Cost: Provider capitation payments were based on FY 2020-21 rebased rates, trended for differences in Fee for Service (FFS) contract terms, as well as reassessment of rebasing trend assumptions. The results of this analysis are included in the rate adjustments effective July 1, 2021.

FFS costs were based on historical claims trended to June 30, 2022, and were developed by network type, COA, and category of service. Staff proposes the below provider reimbursement changes to ensure appropriate funding and network adequacy.

Table 7: Updates to Provider Reimbursement Rates for Medi-Cal Classic

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Increase	• Child: +3.0% Professional +7.4% Facility • Adult: 0% Professional +4.6% Facility • SPD: 0% Professional, +4.8% Facility	$9.3M

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Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Hospital Inpatient	Increase	• Increase of 3.75% from 108% to 112% of All Patients Refined Diagnosis Related Groups (APR-DRG)	$4.1M
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($0.3M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$1.1M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	$2.5M
Ancillary Provider Rate	Increase	• Mental Health (Non-Applied Behavioral Analysis (ABA)): +15% unit cost increase for fee schedule change	$1.6M

Medi-Cal Expansion
Expansion Enrollment: The budget projects an 8.2% increase in total member months.

Expansion Revenue: DHCS continues to make material adjustments to the Medi-Cal Expansion revenue rate. The budget estimates that base rates effective January 1, 2022, will be reduced by an additional 3% to account for anticipated population risk.

Expansion Medical Cost: Provider capitation payments were reduced 9.0% for Professional services and 12.0% for Facility services. The most recent rebasing analysis completed in July 2020 supports the rate adjustments for the Medi-Cal Expansion population effective July 1, 2021.

FFS cost trends were developed by network type, COA, and category of service. Staff proposes the below provider reimbursement changes to ensure appropriate funding and network adequacy.

Table 8: Updates to Provider Reimbursement Rates for Medi-Cal Expansion

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Decrease	• Professional: (9%) • Facility (12%)	($56.1M)
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($0.3M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$1.4M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	$1.2M
Ancillary Provider Rate	Increase	• Mental Health (Non-ABA): +15% unit cost increase for fee schedule change	$2.1M

Medi-Cal Whole Child Model
WCM Enrollment: The budget projects a 1.6% increase in total member months.

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WCM Revenue: The budget assumes that rates will decrease by 1.0% effective January 1, 2022. Rates reflect reimbursement for both California Children's Services (CCS) and non-CCS services.

WCM Medical Cost: Staff has analyzed and repriced experience data for the WCM population to set updated capitation rates. CalOptima provides capitation with a risk corridor to Health Networks. In creating WCM expense projections, the primary components of medical costs include Hospital Inpatient Facility expenses, LTC services, and Pharmacy services. Staff proposes the below provider reimbursement changes to ensure adequate funding and network adequacy. The resetting of network capitation and the carve-out of Private Duty Nursing (PDN) will ensure timely and appropriate payments based on networks' delegated risk with less dollars flowing through the risk corridor.

Table 9: Updates to Provider Reimbursement Rates for Medi-Cal WCM

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Neutral	• Professional: +49.7% • Facility: (18.3%)	~$0
Hospital Inpatient	Increase	• Increase of 3.75% from 108% to 112% of APR-DRG	$0.3M
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($3.7M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$0.1M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	~$0
Ancillary Provider Rate	Increase	• Mental Health (Non-ABA): +15% unit cost increase for fee schedule change	$0.1M
Division of Financial Responsibility (DOFR)	HMO/PHC Savings	• Carve-out of EPSDT Private Duty Nursing	$18M*

* Minimal net operating budget impact since less dollars will be paid through the interim catastrophic reimbursement mechanism and risk corridor settlement

B. OneCare Connect

Through a three-way contract with the Centers for Medicare & Medicaid Services (CMS), DHCS, and CalOptima, CalOptima began the OneCare Connect Program in July 2015. The Cal MediConnect program is a joint Medicare and Medicaid demonstration program that promotes coordinated health care delivery to SPD members who are dually eligible for Medicare and Medi-Cal services. The initial demonstration period was October 1, 2013, through December 31, 2019. On April 24, 2019, CMS approved a three (3) year extension of the program through December 31, 2022.

Of note, with the implementation of the CalAIM program, the state will discontinue the Cal MediConnect Program effective December 31, 2022. At that point, CalOptima will transition all

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OneCare Connect members to the OneCare program effective January 1, 2023. Staff will include these program changes in the FY 2022-23 Operating Budget. The table below illustrates the OneCare Connect Operating Budget.

Table 10: FY 2021-22 OneCare Connect Operating Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	14,144	14,669	15,112
Revenue	$317,641,603	$342,968,732	$339,332,450
Medical Costs	$295,701,390	$324,443,397	$322,091,108
Administrative Expenses	$19,784,049	$18,012,775	$22,358,995
Operating Income/Loss	$2,156,164	$512,560	($5,117,653)
MLR	93.1%	94.6%	94.9%
ALR	6.2%	5.3%	6.6%

* Forecasted as of March 2021
Note: FY 2019-20 Actual and FY 2020-21 Forecast include prior year adjustments

General Budget Assumptions – OneCare Connect
Enrollment: Average OneCare Connect membership is projected to increase by approximately 2.1% from FY 2020-21 through FY 2021-22.

Revenue: The budget utilizes the most current county benchmark base rates from CY 2021 for Medicare Parts C and D. Rates were not developed from a bid process that uses actual plan data. The budgeted trends reflect a combination of projected Risk Adjustment Factors (RAF), base rates, and other adjustments. Staff assumed a 3.2% increase to Part C revenue and a 3.9% increase to Part D revenue, effective January 2022. This includes a Year 3+ savings target of 5.5% and a quality withhold of 4.0%. The suspended 2% sequestration reduction will resume on January 1, 2022. In addition, disenrollment rate penalties will continue to apply.

Staff applied Medi-Cal draft CY 2021 rates from DHCS and adjusted forecasted enrollment in the specified population cohorts. The final Medi-Cal revenue will be adjusted to reflect the actual population mix.

Medical Cost: Provider capitation payments were based on Percent of Premium (POP) rates for the Medicare component and fixed per member per month (PMPM) rates for the Medi-Cal component. The most recent rebasing analysis on Health Network POP percentages which resulted in an adjustment to the Facility capitation rate from 50.9% to 45% beginning January 1, 2021. FY 2021-22 will be the first fiscal year forecasted with a full 12 months of the reduced POP percentage. This is the primary driver for the lower program operating deficit.

FFS expenses were projected based on actual OneCare Connect experience by service type, trended through June 2022. Staff evaluated and trended experience by risk arrangement, such as Physician Hospital Consortia (PHC), Shared Risk Groups (SRG), Health Maintenance Organizations (HMO), and the CalOptima Community Network (CCN). The budget includes projected increases from actuals in utilization of NMT, Skilled Nursing Facility services, Hospital Inpatient Facility services, Hospital

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Outpatient Facility services, Pharmacy services and a decrease in LTC expenses. It also includes costs for Managed Long-Term Supports and Services (MLTSS) services, as well as quality improvement programs. Approved existing supplemental benefits effective January 1, 2022, such as an enhanced Part D benefit, gym benefit, coverage for emergency room (ER) services worldwide, and an allowance for over-the-counter drugs were also included to mirror the OneCare line of business.

C. OneCare

Through a contract with the CMS, CalOptima has administered a Medicare Advantage Dual Eligible Special Needs Plan since October 2005. OneCare will continue to provide services for beneficiaries not eligible for the OneCare Connect program. The table below illustrates the OneCare Operating Budget.

Table 11: FY 2021-22 OneCare Operating Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	1,463	1,609	1,782
Revenue	$15,950,203	$24,252,182	$25,409,771
Medical Costs	$15,843,761	$22,382,251	$24,233,492
Administrative Expenses	$1,672,376	$1,868,292	$2,153,921
Operating Income/Loss	($1,565,934)	$1,639	($977,642)
MLR	99.3%	92.3%	95.4%
ALR	10.5%	7.7%	8.5%

* Forecasted as of March 2021
Note: FY 2019-20 Actual and FY 2020-21 Forecast include prior year adjustments.

General Budget Assumptions – OneCare

Enrollment: Average OneCare membership is projected to increase approximately 8.8% from FY 2020-21 through FY 2021-22.

Revenue: The budget utilizes the most current rates developed through the annual bid process. The budgeted trends are due to a combination of projected RAF, base rates, and other adjustments. Staff assumed a 0.4% increase to Part C revenue and a 2.5% increase to Part D revenue, effective January 1, 2022. The suspended 2% sequestration reduction will resume on January 1, 2022.

Medical Cost: Professional provider capitation payments were based on an average 38.6% POP, inclusive of quality incentive payments. FFS expenses were projected based on actual OneCare experience by service type, trended through June 30, 2022. The budget includes projected increases in Skilled Nursing Facility utilization, Hospital Inpatient Facility PMPM, Hospital Outpatient Facility PMPM, and Pharmacy unit cost. Approved existing supplemental benefits effective January 1, 2022, such as an enhanced Part D benefit, gym benefit, coverage for ER services worldwide, and an allowance for over-the-counter drugs were also included.

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D. PACE

Through a contract with CMS, CalOptima began Orange County's first PACE program on October 1, 2013. The PACE program provides coordinated care for persons age 55 and older who need a higher level of care to remain in their homes. The table below illustrates the PACE Operating Budget.

Table 12: FY 2021-22 PACE Operating Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	380	387	413
Revenue	$37,438,160	$38,878,307	$40,274,039
Medical Costs	$29,648,249	$32,718,478	$36,102,675
Administrative Expenses	$2,204,067	$1,839,770	$2,694,968
Operating Income/Loss	$5,585,845	$4,320,059	$1,476,397
MLR	79.2%	84.2%	89.6%
ALR	5.9%	4.7%	6.7%

* Forecasted as of March 2021

Though PACE continues to run efficiently, Management will continue to focus on several areas of opportunities to improve the PACE program, including:

- Resume use and expansion of Alternative Care Settings (ACS) for improved member access and expansion of the service area after the PHE is lifted;
- Ensure accurate reporting of experience and cost data through the RDT filing and advocate as needed through our professional associations for improved transparency in the rate setting process with DHCS;
- Improve medical cost containment efforts;
- Implement initiatives to gain greater administrative efficiencies and operational economies of scale; and
- Maintain improvements made in appropriate coding and submission of diagnostic data.

General Budget Assumptions – PACE

Enrollment: Due to the impact COVID-19 PHE has had on the program, the budget forecasts flat enrollment from current through June 30, 2021, and then a steady ramp-up in growth rate throughout the budget year, starting at 2 members per month in July 2021 and ending at 6 members per month in June 2022. Enrollment is forecasted to end at 440 members by June 30, 2022. The member population is projected to consist of 47% dual eligible members and 53% Medi-Cal only members.

Revenue: The budget applies rates from CY 2021 actuals for Medicare Parts C and D. Staff projects a 9.0% increase to Part C PMPM revenue effective January 2022, primarily driven by RAF score improvements. Medicare Part D rates and subsidies were based on CY 2021 payments. The budget includes a forecasted increase in revenue of 2.4% as compared to the prior year's budget. No additional trend assumptions were applied. Medi-Cal PMPM rates were based on CY 2021 rates provided by DHCS on December 3, 2020. These rates are 1.6% lower than the prior year's budget. The suspended 2% sequestration reduction will resume on January 1, 2022.

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Medical Cost: Medical costs were projected using actual experience. The budget includes sufficient utilization trends in physician services, Community-Based Adult Services due to forecasted ACS enrollment, home care, dialysis, transportation, and pharmacy utilization. Staff reclassified 96% of PACE Center expenses as medical costs to better reflect the actual costs of delivering member care.

E. Investment Income

The table below illustrates projected net investment income.

Table 13: Investment Income

	FY 2019-20 Actual	FY 2020-21 YTD Forecast*	FY 2021-22 Budget
Investment Income	$43,027,431	$6,256,601	$10,000,000

* Forecasted as of March 2021

Budget Assumptions – Investment Income

The FY 2021-22 Operating Budget projects $10,000,000 in net investment income. The budget is lower than prior years based on current market conditions and projected return on investments in FY 2021-22.

Fiscal Impact

As outlined above and described in Attachment A: FY 2021-22 Budget for all Lines of Business, the FY 2021-22 Operating Income reflects a projected loss of $68.4 million. The budget includes a projected investment income of $10 million, resulting in a total decrease of $58.4 million in net assets. Management proposes to use reserves to address the anticipated FY 2021-22 budget shortfall.

Rationale for Recommendation

Management submits the FY 2021-22 Operating Budget for all program areas using the best available assumptions to provide health care services to CalOptima's forecasted enrollment.

Concurrence

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

Attachments

1. Attachment A: FY 2021-22 Budget for all Lines of Business
2. Attachment B: Administrative Budget Details

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

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Attachment A

CalOptima Fiscal Year 2021-22 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	6,265,845	3,466,738	133,908	9,866,491	181,341	21,382	4,953	2,730	-	**10,074,167**
Avg Members	522,154	288,895	11,159	822,208	15,112	1,782	413	455	-	**839,514**
Revenues										
Capitation revenue	$ 1,676,092,280	$ 1,336,597,706	$ 237,188,674	$ 3,249,878,660	$ 339,332,450	$ 25,409,771	$ 40,274,039	$ 1,218,536	$ -	**$ 3,656,113,456**
Total	$ 1,676,092,280	$ 1,336,597,706	$ 237,188,674	$ 3,249,878,660	$ 339,332,450	$ 25,409,771	$ 40,274,039	$ 1,218,536	$ -	**$ 3,656,113,456**
Medical Costs										
1 Provider capitation	$ 465,241,785	$ 532,861,966	$ 92,591,963	$ 1,090,695,714	$ 143,668,277	$ 6,785,567	$ -	$ -	$ -	**$ 1,241,149,558**
2 Claims Payments	$ 590,636,596	$ 449,489,060	$ 68,758,294	$ 1,108,883,950	$ 65,335,099	$ 8,663,244	$ 17,133,053	$ -	$ -	**$ 1,200,015,346**
3 LTC/Skilled Nursing Facilities	$ 436,617,694	$ 46,351,961	$ 23,887,069	$ 506,856,724	$ 16,976,719	$ -	$ 582,219	$ 158,410	$ -	**$ 524,574,072**
4 Prescription Drugs	$ 130,255,442	$ 178,661,225	$ 36,604,920	$ 345,521,587	$ 79,340,804	$ 8,226,385	$ 3,994,675	$ -	$ -	**$ 437,083,451**
5 Case Mgmt & Oth Medical	$ 64,457,231	$ 50,979,798	$ 4,705,889	$ 120,142,918	$ 16,770,208	$ 558,297	$ 14,392,728	$ 722,982	$ -	**$ 152,587,132**
Total	$ 1,687,208,748	$ 1,258,344,010	$ 226,548,136	$ 3,172,100,893	$ 322,091,108	$ 24,233,492	$ 36,102,675	$ 881,391	$ -	**$ 3,555,409,559**
MLR	***100.7%***	***94.1%***	***95.5%***	***97.6%***	***94.9%***	***95.4%***	***89.6%***	***72.3%***		***97.2%***
Gross Margin	$ (11,116,467)	$ 78,253,697	$ 10,640,538	$ 77,777,767	$ 17,241,342	$ 1,176,279	$ 4,171,365	$ 337,144	$ -	**$ 100,703,897**
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 95,901,835	$ 10,543,897	$ 880,620	$ 1,855,157	$ 354,746	$ -	**$ 109,536,255**
Professional Fees				$ 5,312,550	$ 441,000	$ 350,000	$ 2,000	$ 6,750	$ -	**$ 6,112,300**
Purchased services				$ 12,183,620	$ 1,303,282	$ 110,000	$ 491,100	$ -	$ 651,000	**$ 14,739,002**
Printing & Postage				$ 4,605,940	$ 1,657,320	$ 189,869	$ 230,860	$ -	$ 2,000	**$ 6,685,989**
Depreciation & Amortization				$ 5,910,000	$ -	$ -	$ 4,800	$ -	$ 2,472,000	**$ 8,386,800**
Other Operating Expenses				$ 21,108,133	$ 252,865	$ 12,350	$ 51,716	$ 43,846	$ 2,330,000	**$ 23,798,910**
Indirect Cost Allocation, Occupancy Expense				$ (3,593,146)	$ 8,160,631	$ 611,082	$ 59,335	$ 29,307	$ (5,455,000)	**$ (187,791)**
Total				$ 141,428,932	$ 22,358,995	$ 2,153,921	$ 2,694,968	$ 434,649	$ -	**$ 169,071,466**
ALR				***4.4%***	***6.6%***	***8.5%***	***6.7%***	***35.7%***		***4.6%***
Operating Income/(Loss)				$ (63,651,165)	$ (5,117,653)	$ (977,642)	$ 1,476,397	$ (97,505)	$ -	**$ (68,367,569)**
Investment Income										$ 10,000,000
MCO Tax Revenue				$ 168,406,719						$ 168,406,719
MCO Tax Expense				$ (168,406,719)						$ (168,406,719)
CHANGE IN NET ASSETS				**$ (63,651,165)**	**$ (5,117,653)**	**$ (977,642)**	**$ 1,476,397**	**$ (97,505)**	**$ -**	**$ (58,367,569)**

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Attachment B

Medi-Cal: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Legal	General and Adversarial Legal Fees	2,200,000	X	X
Professional Fees	Employee Engagement and Feedback, Executive Recruiter Expenses, Compensation and Classification, Leave and Accommodation and Ad Hoc Consulting	355,500	X	X
Consulting	Internal Audit on Operations	325,000	X	X
Consulting	Rebasing, Network Support and Other Related Actuarial Consulting Services	300,000	X	X
Consulting	Government Affairs Contract and Management of State and Federal Lobbyists	265,000	X	X
Audit Fees	Medical Loss Ratio Audit	250,000	X	X
Professional Fees	Consultant to Assess CalOpima Professional Growth Strategic Plan, including External Investigations, Empower Plan, HR Consulting Services, Outsourcing Leaves of Absence Processing and Others	216,500	X	X
Audit Fees	Financial Audit Annual Contract	200,000	X	X
Consulting	Consulting Fees To Support Program Outreach and Social Media Efforts, Acquiring Data for Strategic Direction	180,000	X	X
Consulting	Support for Implementation of Strategic Plan, Initiatives Aligned with Strategic Plan and Other Programs	150,000	X	X
Consulting	Software Upgrades and Transitions, Security Services and Miscellaneous Consulting/Professional Services	147,800	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	131,000	X	X
Consulting	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management, Assessment and Network Penetration	105,000	X	X
Consulting	Consultant for Medi-Cal Mock Audit, External Peer Review and Other Required Audits	105,000	X	X
Consulting	Investment Advisory Support Services	90,000	X	X
Professional Fees	Professional Fees for Other Post Employment Benefits (OPEB) and Various Accounting and Related Consulting Services	79,000	X	X
Consulting	Chronic Illness and Disability Payment System (CDPS) Renormalization and Coefficient Development	70,000	X	X
Professional Fees	Professional Fees for External Peer Review	60,000	X	X
Professional Fees	Professional Fees for Budget and Procurement Support	40,000	X	X
Consulting	Space Planning Services	18,000	X	X
Consulting	Annual IBNR Certification Review	18,000	X	X
Consulting	A-133 Annual Audit Requirement	6,750	X	X
	Total Professional Fees	**5,312,550**		

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Medi-Cal: Purchased Services				
Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Claims Review	Claims Prepayment Editing Services	2,040,000	X	X
Claims Review	Overpayment Identification Services	1,450,000	X	X
Purchased Services	Pharmacy Benefits Management	1,300,000	X	X
Claims Review	Coordination Of Benefits (COB) Project	1,200,000	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Institutional Claims	1,094,000	X	X
Interpretive Services	Face to Face Interpreter Services	660,000	X	X
Purchased Services	Conversion of Temporary Assistance for Needy Families (TANF) to Supplemental Security Income (SSI)	560,000	X	X
Bank Fees	Business Bank Fees	400,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	384,000	X	X
Interpretive Services	Telephonic Interpreter Services	381,000	X	X
Claims Review	Long Term Care Rate Adjustments	350,000	X	X
Imaging Services	Claims Imaging and Indexing Services	350,000	X	X
Purchased Services	Disaster Recovery Technology Services	240,000	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for Pdf Files to Make Member, Provider, Board and Other Materials Accessible to People With Disabilities on the Website as Required by CMS, DHCS and Section 508 Regulations	225,000	X	X
Advertising	Radio, Television, Print, Outdoor, Digital Advertising and Other Media to Promote and Support Awareness Campaigns and Satellite Office Campaign	181,000	X	X
Advertising	Radio, Television, Print, Outdoor, Digital Advertising and Other Media to Promote and Support COVID-19 and Behavioral Health Campaigns	166,000	X	X
Broker Services	Insurance Broker Services	130,000	X	X
Advertising	Recruitment Advertisement and Sourcing	120,000	X	X
Purchased Services	Benefit Broker Services	115,000	X	X
Interpretive Services	Translation Services for Threshold Languages	99,000	X	X
Purchased Services	Medicare Third Party Liability (TPL)	60,000	X	X
Purchased Services	Healthcare Productivity Automation Services	60,000	X	X
Purchased Services	Telework, Handling, and Deliveries	57,000	X	X
Employee Benefits	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	55,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services	54,000	X	X
Purchased Services	Executive Coaching	50,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	Background Screening	45,600	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	43,100	X	X
Purchased Services	Employee Assistance Program	39,420	X	X
Purchased Services	Member Experience Survey and Workforce Enhancement	36,000	X	X
Purchased Services	TB Shots and Other General Purchased Services	33,000	X	X
Purchased Services	Claims Pricing Automation Enhancements & Other Purchased Services	25,000	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	22,200	X	X

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	Medi-Cal: Purchased Services			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Interpretive Services	Video Interpreting, Translation Audit Review, Annual Translation Skills Assessment, New Hire Bilingual Testing and In-Design License	21,600	X	X
Purchased Services	Online Phishing Testing Service, Security Newsletter Subscription and Other Services	20,000	X	X
Purchased Services	Funding for Photography and Video Production Services Needed to Support New CalOptima Initiatives	15,000	X	X
Purchased Services	Destruction of Electronic Media	12,000	X	X
Purchased Services	Drug Screenings	12,000	X	X
License fees	Compensation System Subscription Fee	9,000	X	X
Purchased Services	Salary Survey	7,500	X	X
Purchased Services	Promotional Activity (October Cyber Security Awareness Month) Annually	5,000	X	X
Purchased Services	Imaging Services	3,600	X	X
Purchased Services	General Services for Customer Services, Operations Management, Executive Office, Audit & Oversight, and Other Various Departments	2,600	X	X
	Total Purchased Services	**12,183,620**		

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Medi-Cal: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Printing	Print and Fulfillment for Regular Mailings of Daily/Monthly Packets	1,763,100	X	X
Postage	Postage for Maintenance of Business, Direct Mailer, ID Cards, and In Lieu of Services Benefits Flier	1,600,560	X	X
Postage	General Postage for Outgoing Mail	570,000	X	X
Printing	Print and Fulfillment for Newsletters	300,000	X	X
Printing	California Advancing and Innovating Medi-Cal (CalAIM) Mailing, In Lieu of Services Inserts and New ID Cards	110,640	X	X
Courier	Printing of the Annual Report to the Community, Holiday Cards, Provider Press Newsletter, Stock Photo Fees and Ad Hoc Collateral Materials	72,000	X	X
Printing & Postage	Mail Services Charges, Courier/Delivery of Print Materials	48,500	X	X
Printing	CalOptima Brochures, Infographic, CalOptima Programs and Services and CalOptima Posters for Community Outreach Events	37,350	X	X
Printing & Postage	Provider Relations Provider Directory Validation Forms, Annual In-Service Letters and Attestation Forms, Access and Availability Required Mailings and Postage Required to Ensure Provider Training and Education Compliance	32,000	X	X
Printing	Miscellaneous Member Materials, Printing Expenses and Supplies for Various Departments	29,690	X	X
Printing	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Departments' Printing Needs	24,000	X	X
Printing & Postage	Strategic Plan and Other Initiatives Reporting to Community	10,500	X	X
Printing	Flyers, Brochures and Trigger Monitoring Letter Campaign	7,600	X	X
	Total Printing & Postage	**4,605,940**		

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Medi-Cal: Other Operating Expenses				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Equipment	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets and Accessories)	1,800,000	X	X
Maintenance	Facets Core System (Enrollment, Claims, Authorizations and Other Modules) License Renewal and Maintenance. Facets True Up Membership	1,783,000	X	X
Insurance	Insurance Premiums - Errors and Omissions Professional Liability - General and Property Liabilities - Excess Liabilities - Commercial Auto - Directors and Officers (D&O) - Network/Privacy (Cyber), Crime, Employment Practices Liability (EPL) - Earthquake, Pollution and Umbrella - Wage and Hour Coverage	1,670,000	X	X
Maintenance	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance and Other Corporate Applications)	1,611,447	X	X
Maintenance	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,500,000	X	X
Maintenance	Network Connectivity Maintenance and Support for CalOptima Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,259,000	X	X
Maintenance	Information Security Data Loss Prevention Solution Annual Maintenance	1,227,200	X	X
Maintenance	User Licenses for Medicare Claims Pricing Software	981,000	X	X
Maintenance	CalOptima Link Software Licenses, an Online System for Provider Networks to Submit and View Authorizations, Check Claim Status and Remittance Payment Advice and to Verify Member Eligibility for Point of Service and Care	792,000	X	X
Maintenance	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	727,000	X	X
Equipment	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, and Other Minor Computer Equipment, Laptop and Desktop Replacements	595,004	X	X
Training & Seminar	Training & Seminar - Professional Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	470,070	X	X
Maintenance	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	465,000	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Professional Dues	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	464,730	X	X
Maintenance	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	433,325	X	X
Maintenance	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	429,360	X	X
Subscriptions	Cloud Government/Storage Subscription	420,000	X	X
Subscriptions	Healthcare Information Research and Analysis, Information Systems Audit and Control, Association Subscription Renewal	413,295	X	X
Maintenance	Contract Management System	355,000	X	X
Maintenance	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	311,000	X	X
Education	Tuition Reimbursement for Staff Development and Organizational Development Programs (CalOptima Special Speakers, Trainers, Computer Classes, Other Training Events)	248,000	X	X
Office Supplies	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health and Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	240,000	X	X
Maintenance	Provider and Physician Credentialing System Maintenance and License Renewal	223,000	X	X
Maintenance	Maintenance and Support for the Production/Development of Citrix Operating System/Software Environments	217,500	X	X
Equipment	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture and Equipment, and Various Other Articles of Minor Equipment	210,000	X	X
Maintenance	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	200,000	X	X
Maintenance	24/7 Support to Assist CalOptima's Operating Systems and Office Software Suite Related Questions and Issues	200,000	X	X
Repair & Maintenance	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	192,000	X	X
Maintenance	Finance Corporate Applications Software Maintenance (Accounting, Finance and Procurement Systems)	181,200	X	X
Public Activities*	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events and Health Fairs	159,000	X	X
Training	Board Member Stipends, Memberships, Conferences, Training and Travel	159,000	X	X
Equipment	Computer Laptops 4 Year Replacement Program	150,000	X	X
Maintenance	Software to Generate and Interface with Facets Letters	145,000	X	X
Maintenance	Maintenance of Computer Software and Hardware	87,400	X	X
Maintenance	Database Administrator License Renewals, Maintenance and Support	86,500	X	X

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Medi-Cal: Other Operating Expenses				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Travel	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	75,680	X	X
Professional Dues	Professional Dues and Member Fees for Various Professional Associations	75,256	X	X
Office Supplies	Office Supplies for Various Departments' Needs for Everyday Operations	69,352	X	X
Maintenance	Information Services Corporate Software Maintenance - Enterprise Help Desk Management Application	66,000	X	X
Maintenance	Maintenance and Support for Batch Scheduler System	57,000	X	X
Subscriptions	Subscription Fees for Various Licenses, Literature and Organizations	40,219	X	X
Food Services	Employee Appreciation Events	40,000	X	X
Public Activities	Orange County Community Indicators Report, New and Expanded Strategic Planning Engagement and Rollout and Affiliation Fees	39,000	X	X
Subscriptions	Subscriptions for Existing Software and Databases	33,300	X	X
Public Activities	Employee Engagement Events	27,400	X	X
Maintenance	Annual Maintenance for MSSP Software License	25,000	X	X
Maintenance	Maintenance and Support for Printers	15,000	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Department Meetings and Other Events	14,800	X	X
Subscriptions	Subscription Fees for Electronic Surveys, Education Videos for Members and Associations	13,545	X	X
Food Services	General Supplies for CalOptima Staff	12,000	X	X
Maintenance	Accounting Software Annual Maintenance	12,000	X	X
Professional Dues	Medical Licenses and Required Certifications	11,500	X	X
Telephone	Field Staff Phone Service and Other Telephone Expenses	11,200	X	X
Software	Computer Software for Medical Coding and Design of Print Materials and Other Related Expenses	11,000	X	X
Food Services	Food Services for Community Events and Supporting New Initiatives	10,000	X	X
Public Activities	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	9,400	X	X
Maintenance	Maintenance and Renewal for Procurement Software	8,000	X	X
Subscriptions	Subscription Fees for Both Clinical and Programmatic Support, and Normal Maintenance of Certification Licensure	7,200	X	X
Food Services	Food Services for Provider Advisory Committee, CalOptima Community Network Lunch and Learn Events and CCN Anniversary Event	6,000	X	X
Food Services	Food Services for Advisory Committees, Existing and New Collaboratives, Stakeholder Engagement For New Initiatives	3,600	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Food Services	Food Services for CalOptima Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	3,150	X	X
Public Activities	Promotional and Outreach Activities to Help Support CalOptima Progams and Initiatives	3,000	X	X
Food Services	Food Services for Annual CalOptima Event to Promote Mental Health Awareness and Other Events	2,000	X	X
Other Expenses	State Non-Reimbursable Funds for Services and Items for MSSP Clients	500	X	X
	Total Other Operating Expenses	**21,108,133**		

* All Community Events and Activities Involving Financial Support from CalOptima of Over $1,000 Requires Prior Explicit Board Approval

Attachment B

OneCare Connect: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Consulting	Centers for Medicare & Medicaid Services (CMS) Program Audit for OneCare and OneCare Connect	300,000	X	X
Consulting	Annual Compliance Program Effectiveness (CPE) Audit	84,000	X	X
Actuary	Percentage of Premium Sufficiency, Fully-Integrated Special Needs Plans (FIDE SNP) Consideration and Other Related Actuarial Consulting Services	30,000	X	X
Consulting	CMS Data Validation Audit	27,000	X	X
	Total Professional Fees	**441,000**		

OneCare Connect: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Purchased Services	Pharmacy Benefits Management	777,600	X	X
Advertising	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	297,000	X	X
Interpreter Services	Language Interpretation, Face to Face Interpreter Services and Translation of Member Materials	98,232	X	X
Data Transmission	Claims Processing through Automation Data Flow	54,000	X	X
Purchased Services	Annual Assessments for Members	50,000	X	X
Purchased Services	Compliance and Ethics Hotline	26,000	X	X
Purchased Services	Purchased Services Needs for Customer Service	450	X	X
	Total Purchased Services	**1,303,282**		

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OneCare Connect: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Member Communications	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	785,000	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	571,800	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials and Other Related Printing Expenses	297,000	X	X
Member Communications	Member and Provider Materials, Compliance Week Printing and Fulfillment and Other Printing Fees for Various Departments	3,520	X	X
	Total Printing & Postage	**1,657,320**		

OneCare Connect: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Public Activities	Fees for Member Outreach Activities and Promotional Items for Community Events	145,000	X	X
Public Activities	Fees for Promotional Items for Community Events, Sponsorships and Registration Fees and Venue Rental	35,000	X	X
Public Activities	Marketing and Outreach Activities and Promotional Items for Various Events	17,500	X	X
Training & Seminars	Training and Seminars for Professional Development and Education	14,285	X	X
Travel	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences	13,200	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	10,300	X	X
Subscriptions	Subscriptions and Professional Dues	9,580	X	X
Equipment	Purchases and Installation of Office Furniture and Various Other Articles of Minor Equipment	4,500	X	X
Office Supplies	Office Supplies Needed for Everyday Department Operations and Compliance Week Supplies	2,900	X	X
Telephone	Telephone Expenses	600	X	X
	Total Other Operating Expenses	**252,865**		

Attachment B

OneCare: Professional Fees

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Consulting	Annual Contract Bid for OneCare, Rebasing and Other Actuarial Services	350,000	X	X
	Total Professional Fees	**350,000**		

OneCare: Purchased Services

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Purchased Services	Pharmacy Benefits Management	90,000	X	X
Interpreter Services	Language Interpretation and Translation of Member Materials	20,000	X	X
	Total Purchased Services	**110,000**		

OneCare: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage)	98,869	X	X
Member Communications	Member Enrollment and Other Required Materials	52,000	X	X
Member Communications	Member Enrollment and Direct Mailers (Printing, Fulfillment, Postage)	39,000	X	X
	Total Printing & Postage	**189,869**		

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OneCare: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Food Services	Food Services for Department Training and Other Events	5,050	X	X
Travel	Travel Expenses for Conferences/Seminars and Meetings	3,000	X	X
Professional Dues	Professional Certifications	1,500	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	1,500	X	X
Office Supplies	Office Supplies Needed for Daily Operations	1,300	X	X
	Total Other Operating Expenses	**12,350**		

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PACE: Professional Fees

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	2,000	X	X
	Total Professional Fees	**2,000**		

PACE: Purchased Services

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	486,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services, Telehealth Support Services, Medical Equipment Calibration and Other Related Expenses	5,100	X	X
	Total Purchased Services	**491,100**		

PACE: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	230,860	X	X
	Total Printing & Postage	**230,860**		

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PACE: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Public Activities	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	19,488	X	X
Repairs & Maintenance	Software License and Support, Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	18,148	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences and Trainings	5,100	X	X
Utilities	Electricity, Gas, Water and Other Related Expenses	3,120	X	X
Insurance	General Liability, Property, Earthquake and Other Insurance Fees	2,200	X	X
Training	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	984	X	X
Property Tax	Property Tax Assessment	800	X	X
Minor Equipment & Supplies	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic Small Equipment)	564	X	X
Travel	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	492	X	X
Supplies	Office Supplies for Staff	412	X	X
Subscriptions	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	408	X	X
	Total Other Operating Expenses	**51,716**		

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MSSP: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Consulting	A-133 Annual Audit Requirement	6,750	X	X
	Total Professional Fees	**6,750**		

MSSP: Other Operating Expenses				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Maintenance	Information Management Software for Long Term Care	25,000	X	X
Telephone	Cell Phones and Data Plans for Field Staff and Management Team Who Complete Onsite Home Assessments	11,200	X	X
Travel	Regular Home Visits with Members for Field Staff	3,246	X	X
Professional Dues	Professional Certifications	2,750	X	X
Training & Seminar	Professional Development and Education	750	X	X
Other Expenses	Member Services Provided by Care Managers	500	X	X
Office Supplies	Routine Office Supplies for Field and Office Staff	400	X	X
	Total Other Operating Expenses	**43,846**		

Attachment B

Facilities: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Fire/Life Safety Security	Security Contract	366,000	X	X
Building Administration	Property Management, Administration Fee and Other Related Expenses	285,000	X	X
	Total Purchased Services	**651,000**		

Facilities: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022 Input**	**Authorization**	**Appropriation**
Postage	Postage and Courier	2,000	X	X
	Total Printing & Postage	**2,000**		

	Facilities: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022 Input	Authorization	Appropriation
Utilities	Electricity	441,000	X	X
Janitorial	Janitorial Night Contract	375,800	X	X
Repairs & Maintenance	Engineering Contract	242,467	X	X
Insurance	Property, Liability and Earthquake Insurance	237,000	X	X
Janitorial	Janitorial Day Contract	137,385	X	X
Repairs & Maintenance	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Deor, CAM, Other Maintenance)	121,604	X	X
Janitorial	Janitorial Supplies	86,400	X	X
Parking Lot Maintenance	Parking Lot Maintenance and Sweeping	84,300	X	X
Repairs & Maintenance	Plumbing	77,340	X	X
Repairs & Maintenance	Electrical Repairs and Supplies	75,250	X	X
Fire/Life Safety Security	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	70,653	X	X
Repairs & Maintenance	HVAC Miscellaneous	65,548	X	X
Landscape	Exterior Landscape Contract	45,537	X	X
Repairs & Maintenance	Walls/Ceilings/Floors/Sidewalks/Railings	39,500	X	X
Repairs & Maintenance	Windows	30,072	X	X
Repairs & Maintenance	Elevator Maintenance Contract	27,600	X	X
Repairs & Maintenance	HVAC Maintenance Contract	25,448	X	X
Utilities	Water - Building	24,000	X	X
Fire/Life Safety Security	Security Equipment and Maintenance	21,880	X	X
Repairs & Maintenance	Water Treatment	21,536	X	X
Property Tax	Property Tax Assessments	21,000	X	X
Landscape	Landscape Extras	18,280	X	X
Utilities	Gas	17,000	X	X
Utilities	Trash	11,000	X	X
Repairs & Maintenance	Door Maintenance and Repair	8,800	X	X
Repairs & Maintenance	Painting	3,600	X	X
	Total Other Operating Expenses	**2,330,000**		

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CalOptima

Better. Together.

Fiscal Year 2021-22 Operating Budget

Board of Directors Meeting
June 3, 2021

Nancy Huang, Chief Financial Officer

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FY 2021-22 Consolidated Budget Overview

Current Environment

- COVID-19 Pandemic
  - End of Public Health Emergency (PHE) expected January 2022
  - County will begin resuming normal Medi-Cal eligibility activity
    - Will have direct impact on CalOptima's enrollment

- May Revise (released on 5/14/21)
  - FY 2021-22 State Budget of $267.8 billion ($196.8 billion General Fund)
  - Includes $100 billion California Comeback Plan of $75.7 billion in budget surplus and $25 billion in federal relief
  - Next step: Legislature will finish budget hearings and finalize budget for passage by 6/15/21

Enrollment Trends (updated)

TOTAL AVERAGE MEMBER MONTHS

LOB	FY 2019	FY 2020	FY 2021	FY 2022	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/'20 Δ (#)	'21/'20 Δ (%)	'22/'21 Δ (#)	'22/'21 Δ (%)
MC	751,393	723,978	790,884	822,208	(27,416)	-3.6%	66,906	9.2%	31,324	4.0%
OCC	14,466	14,206	14,807	15,112	(260)	-1.8%	600	4.2%	305	2.1%
OC	1,445	1,460	1,638	1,782	15	1.0%	179	12.2%	144	8.8%
PACE	303	381	389	413	78	25.8%	9	2.2%	24	6.0%
TOTAL	**767,606**	**740,024**	**807,718**	**839,514**	**(27,582)**	**-3.6%**	**67,694**	**9.1%**	**31,796**	**3.9%**

MEMBERSHIP (JUNE OF EACH FISCAL YEAR)

LOB	FY 2019	FY 2020	FY 2021	FY 2022	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/'20 Δ (#)	'21/'20 Δ (%)	'22/'21 Δ (#)	'22/'21 Δ (%)
MC	739,789	742,654	818,299	810,904	2,865	0.4%	75,645	10.2%	(7,395)	-0.9%
OCC	14,194	14,396	14,946	15,078	202	1.4%	550	3.8%	132	0.9%
OC	1,533	1,452	1,742	1,799	(81)	-5.3%	290	20.0%	57	3.3%
PACE	326	391	392	440	65	19.9%	1	0.3%	48	12.2%
TOTAL	**755,842**	**758,893**	**835,379**	**828,221**	**3,051**	**0.4%**	**76,486**	**10.1%**	**(7,158)**	**-0.9%**

*Based on actuals from July 2018 through March 2021

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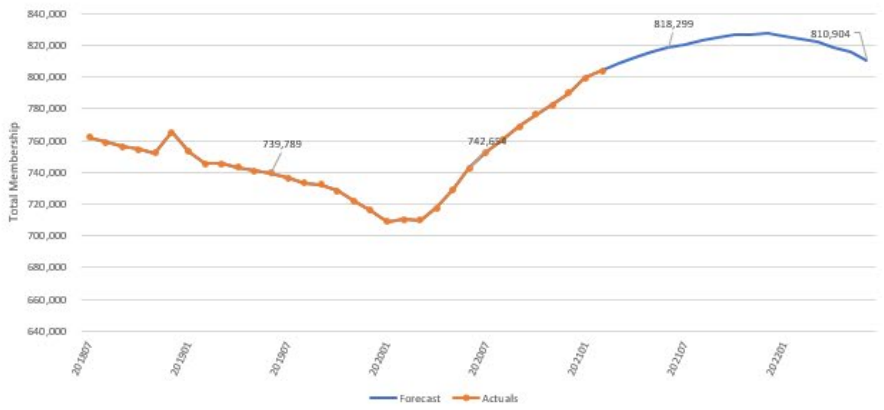
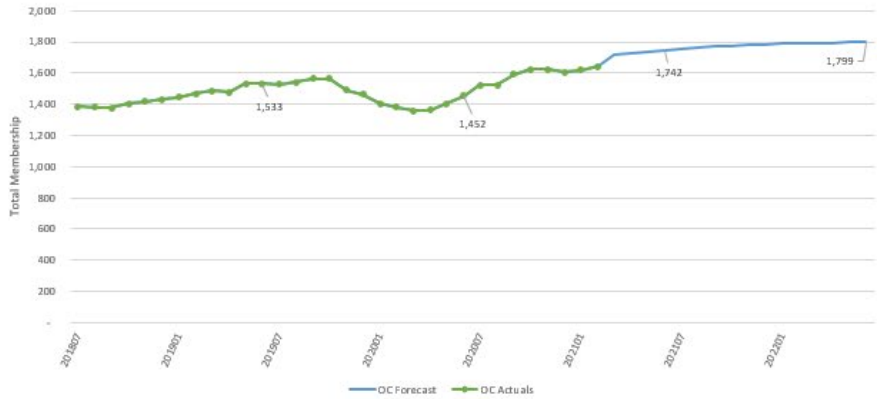
Enrollment (cont.)

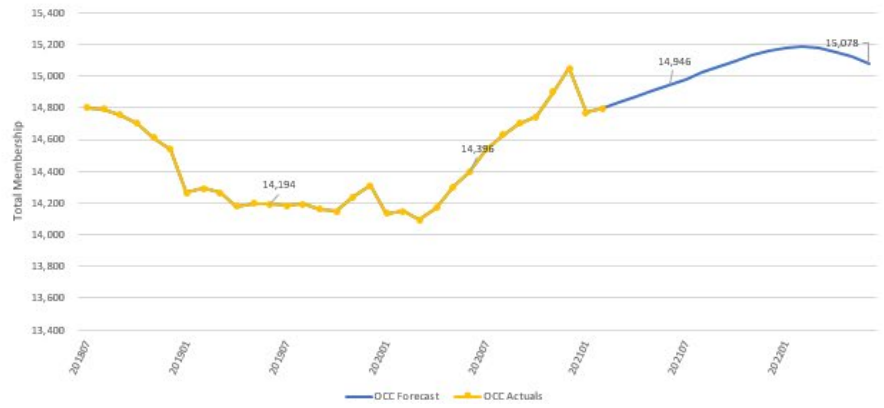
Medi-Cal



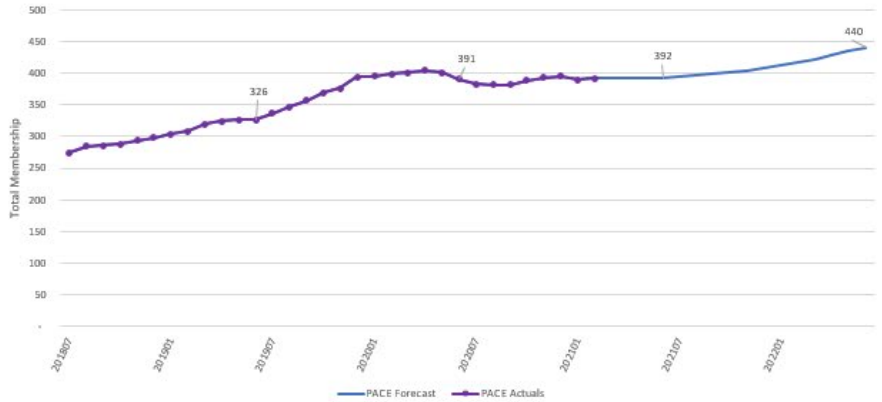
OneCare



OneCare Connect



PACE



*Based on actuals from July 2018 through March 2021

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Income Statement: FY 2020-21 Budget vs. FY 2021-22 Budget

Consolidated	FY 2020-21 Budget **	FY 2021-22 Budget	FY 2021-22 vs. FY 2020-21 Budget
Average Monthly Enrollment	800,302	839,514	39,212
Revenue	$3,555,013,609	$3,656,113,456	$101,099,847
Medical Costs	$3,459,700,922	$3,555,409,559	$95,708,637
Administrative Expenses	$152,054,351	$169,071,466	$17,017,111
Operating Income/Loss	**($56,741,664)**	**($68,367,569)**	**($11,625,901)**
Investments, Net	$15,000,000	$10,000,000	($5,000,000)
Change in Net Assets*	**($41,741,664)**	**($58,367,569)**	**($16,625,901)**
Medical Loss Ratio (MLR)	97.3%	97.2%	(0.1%)
Administrative Loss Ratio (ALR)	4.3%	4.6%	0.3%

* Change in Net Assets excludes other income

** Includes Board actions and budget adjustments as of March 2021

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FY 2020-21 Budget vs. FY 2021-22 Budget: Medical Costs

Consolidated	FY 2020-21 Budget *	FY 2021-22 Budget	FY 2021-22 vs. FY 2020-21 Budget
Revenue	$3,555,013,609	$3,656,113,456	$101,099,847
Provider Capitation	$1,308,597,418	$1,241,149,558	($67,447,860)
Claims Payments	$2,070,140,823	$2,226,157,051	$156,016,228
Long Term Care (LTC)/Skilled Nursing Facilities	$431,356,841	$482,033,558	$50,676,717
Prescription Drugs	$361,086,227	$437,083,451	$75,997,224
Professional, Facility and Other Ancillary	$1,277,697,755	$1,307,040,042	$29,342,287
Case Management & Other Medical	$80,962,681	$88,102,950	$7,140,269
Total	**$3,459,700,922**	**$3,555,409,559**	**$95,708,637**
MLR	97.3%	97.2%	(0.1%)

* Includes Board actions and budget adjustments as of March 2021

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FY 2021-22 Operating Budget by Line of Business

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Medi-Cal

Medi-Cal Program Outlook

Program Update	Timeframe	Budget Assumption
Medi-Cal Rx Carve-out	Effective 1/1/22	State to provide revenue to cover expenses until implementation
Multipurpose Senior Services Program (MSSP) Carve-out		
CalAIM: Whole Person Care and Health Homes Program Transition	Beginning 1/1/22	
CalAIM: Enhanced Care Management/In Lieu of Services	Effective 1/1/22	CalOptima assumes financial risk; payments treated as budget neutral
Proposition 56 Directed Payments Program	Extend program indefinitely (May Revise proposal)	
MCO Enrollment Tax	Authorized through 12/31/22	
Intergovernmental Transfers (IGT)	Calendar Year (CY) 2021 (IGT 11) in process	
Other Board-approved Initiatives (e.g., Homeless Health reserve)	Upon Board approval	Separate Board action

Medi-Cal Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	724,049	783,591	822,208
Revenue	$3,469,816,350	$3,640,183,421	$3,249,878,660
Medical Costs	$3,303,225,031	$3,510,546,468	$3,172,100,893
Administrative Expenses	$118,481,381	$112,846,577	$141,428,932
Operating Income/Loss**	**$48,109,938**	**$16,790,376**	**($63,651,165)**
MLR	95.2%	96.4%	97.6%
ALR	3.4%	3.1%	4.4%

* Forecasted as of March 2021; Revenue excludes directed payments

** Change in Net Assets excludes net investment and other income

Note: Includes MSSP through December 2021

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Medi-Cal Revenue

- Medi-Cal Revenue Rate Assumptions

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal Whole Child Model (WCM)
Base Rates	July – December 2021: CY 2021 rates		
	January – June 2022: Draft CY 2022 rates expected October 2021		
	• Assumes 2% increase	• Assumes 3% reduction	• Assumes 1% reduction • Includes CCS and non-CCS services
BHT/Hepatitis C Rates	FY 2020-21 rates		
Coordinated Care Initiative (CCI) Rates	July 2021 – June 2022: Utilized CY 2021 rates • Reweighted for projected cohort mix		NA

Note: Includes increase in the underwriting gain of 0.5%

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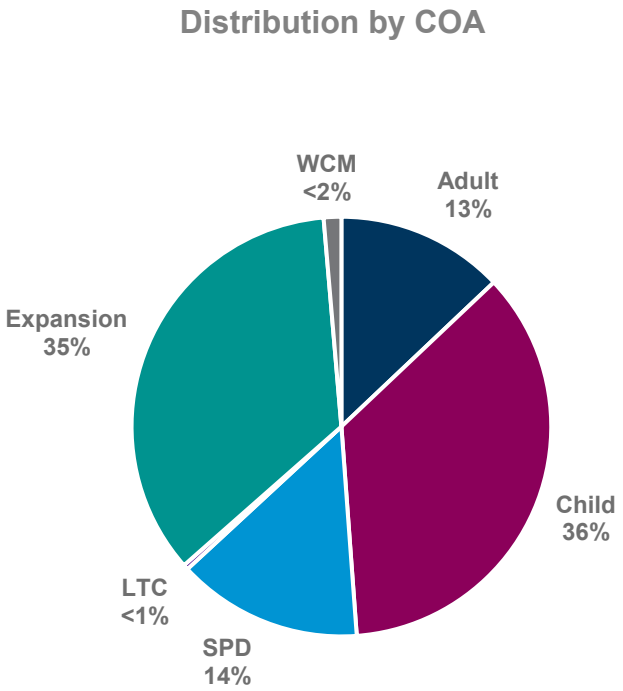
Medi-Cal Average Enrollment

	FY 2020-21 Forecast*	FY 2021-22 Budget	Variance	
			Diff	%
Adult	101,224	106,382	5,157	5.1%
Child	293,057	295,119	2,062	0.7%
SPD	115,382	117,462	2,080	1.8%
LTC	3,211	3,191	(20)	(0.6%)
Medi-Cal Classic Subtotal	**512,874**	**522,154**	**9,280**	**1.8%**
Medi-Cal Expansion	267,024	288,895	21,871	8.2%
WCM	10,986	11,159	173	1.6%
Total	**790,884**	**822,208**	**31,324**	**4.0%**



* Forecasted as of March 2021

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Medical Costs: Provider Rate Updates for Medi-Cal Classic

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Increase	• Child: +3.0% Professional, +7.4% Facility • Adult: 0% Professional, +4.6% Facility • SPD: 0% Professional, +4.8% Facility	$9.3M
Hospital Inpatient	Increase	• Increase of 3.75% from 108% to 112% of All Patients Refined Diagnosis Related Groups (APR-DRG)	$4.1M
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($0.3M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$1.1M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	$2.5M
Ancillary Provider Rate	Increase	• Mental Health (Non-Applied Behavioral Analysis (ABA)): +15% unit cost increase for fee schedule change	$1.6M

Medical Costs: Medi-Cal Classic Health Network Capitation Impact

Cost Type	% Change	$ Change**	Impacted Entities
Professional Capitation	+1.4%	+$3.5M	• Health Networks
Facility Capitation	+5.4%	+$5.9M	• Capitated Hospitals • Health Maintenance Organization (HMO) Networks
Shared Risk Pool	Results from increase to Facility Pool Funding	+$2.3M*	• Shared Risk Group (SRG) Health Networks
Total	**+3.9%**	**+11.6M**	

* Shared Risk Pool funding increased commensurate to Facility Capitation

** Estimated $ Change based on 60% payout.

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Medi-Cal Expansion: Rate History

- California expanded Medi-Cal eligibility in 2014
  - Expected high risk for the newly eligible Expansion population
    - Initial rates were derived based on Disabled population's risk
  - Incentivized plans to develop sufficient provider networks

- Since then, the Department of Health Care Services (DHCS) has made revenue adjustments
  - Expansion population risk is comparable to the Medi-Cal Classic Adult Temporary Assistance for Needy Families (TANF) population
  - Consistently making downward rate adjustments for Expansion

Medi-Cal Expansion: Rate History (cont.)

	Professional Capitation	Facility Capitation	Total Capitation	% Change
Jan 2014	$147.97	$267.66	$415.63	--
Sept 2014	$199.91	$361.61	$561.52	+35.1%
Sept 2015	$170.17	$307.81	$477.98	(15.0%)
July 2016	$144.64	$261.64	$406.28	(15.0%)
July 2017	$144.64	$185.76	$330.41	(18.7%)
July 2019	$133.07	$146.75	$279.82	(15.3%)
July 2020	$123.76	$126.21	$249.96	(10.7%)
Proposed July 2021	$108.83	$109.31	$218.14	(12.7%)

Notes:

- Figures may not add due to rounding
- Capitation amounts are average for all age/gender bands
- Trend differences inclusive of unit cost and enrollment mix differences

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Medi-Cal Expansion: Benchmark Comparison

	Professional Capitation	Facility Capitation	Total Capitation
Proposed July 2021	$108.83	$109.31	$218.14
Expansion July 2020	$123.76	$126.21	$249.96
Recast Expansion July 2020*	$119.60	$124.21	$243.81
PMPM Change	($10.77)	($14.90)	($25.67)
% Change	(9.0%)	(12.0%)	(10.5%)
Adult TANF Classic (FY 2021-22)	$85.44	$91.10	$176.54
PMPM Differential	$23.39	$18.21	$41.60
% Differential	27.4%	20.0%	23.6%

Note: Figures may not add due to rounding

*Recast Expansion July 2020 based on current enrollment

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Medi-Cal Expansion: Fee for Service (FFS) Comparison

	Classic	Expansion	% Over Classic
Professional Services			
Primary Care Physician (PCP)	129%	129%	0.0%
Specialist	133%	156%	17.3%
Hospital Services			
Inpatient	112%	117.3%	4.7%
Outpatient	140%	140%	0.0%

Percent Medi-Cal Equivalent

Based on the prospective rates effective July 2021

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Medical Costs: Provider Rate Updates for Medi-Cal Expansion

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Decrease	• Professional: (9%) • Facility (12%)	($56.1M)
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($0.3M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$1.4M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	$1.2M
Ancillary Provider Rate	Increase	• Mental Health (Non-ABA): +15% unit cost increase for fee schedule change	$2.1M

Medical Costs: Medi-Cal Expansion Health Network Impact

Cost Type	% Change	$ Change	Impacted Entities
Professional Capitation	(9.0%)	($27.6M)	• Health Networks
Facility Capitation	(12.0%)	($20.7M)	• Capitated Hospitals • HMO Networks
Shared Risk Pool	Results from decrease to Facility Pool Funding	($7.8M)	• SRG Health Networks
Total	**(10.5%)**	**($56.1M)**	

* Shared Risk Pool funding decreased commensurate to Facility Capitation

** Estimated $ Change based on 60% payout.

Medical Costs: Provider Rate Updates for Medi-Cal WCM

- Use repriced experience in lieu of DHCS draft rates to set capitation rates
  - Reset capitation rates based on actual experience
  - Maintains risk corridor protection for Health Networks
- Carve-out financial risk for Private Duty Nursing from network capitation
- Management will continue to ensure timely and appropriate payments based on networks' delegated risk
  - Staff will continue to monitor actual experience for future rate setting
  - Appropriate funding will be settled through the annual risk corridor reconciliation process

Medical Costs: Provider Rate Updates for Medi-Cal WCM

Medical Cost	Unit Cost Change	Detail Trend	$ Impact
Network Capitation	Neutral	• Professional: +49.7% • Facility: (18.3%)	~$0
Hospital Inpatient	Increase	• Increase of 3.75% from 108% to 112% of APR-DRG	$0.3M
Hospital Outpatient (Administered Rx)	Decrease	• Reduction of 24.8% from 133% to 100% of Medi-Cal fee schedule	($3.7M)
Hospital Outpatient (Non-Rx)	Increase	• Increase of 5.3% from 133% to 140% of Medi-Cal fee schedule	$0.1M
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase	~$0
Ancillary Provider Rate	Increase	• Mental Health (Non-ABA): +15% unit cost increase for fee schedule change	$0.1M
Division of Financial Responsibility (DOFR)	HMO/PHC Savings	• Carve-out of EPSDT Private Duty Nursing	$18M*

* Minimal net operating budget impact since less dollars will be paid through the interim catastrophic reimbursement mechanism and risk corridor settlement

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OneCare Connect

OneCare Connect and OneCare Program Outlook

Program Update	Timeframe	Budget Assumption
CalAIM: Cal MediConnect ends (i.e., OneCare Connect); OneCare Connect members transition to OneCare	Effective 1/1/23	Not reflected in FY 2021-22 Budget; will be included in FY 2022-23 Budget

OneCare Connect Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	14,144	14,669	15,112
Revenue	$317,641,603	$342,968,732	$339,332,450
Medical Costs	$295,701,390	$324,443,397	$322,091,108
Administrative Expenses	$19,784,049	$18,012,775	$22,358,995
Operating Income/Loss**	**$2,156,164**	**$512,560**	**($5,117,653)**
MLR	93.1%	94.6%	94.9%
ALR	6.2%	5.3%	6.6%

* Forecasted as of March 2021

Note: FY 2019-20 Actual and FY 2020-21 Forecast include prior year adjustments

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OneCare Connect Budget Assumptions: Revenue

- OneCare Connect Revenue Rate Assumptions
  - Year 3+ savings targets of 5.5%
  - Quality withhold of 4%
  - 2% sequestration reduction resumes January 2022

Medicare Part C	Medicare Part D	Medi-Cal**
CMS CY 2021 Monthly Membership Report actuals and CMS CY 2022 rate report*	CMS CY 2021 Monthly Membership Report actuals and CMS CY 2022 rate report*	NA
• Forecasted a 3.2% increase in revenue when compared to FY 2021. Primarily driven by base rates	• Forecasted 3.9% increase when compared to FY 2021. Combination of base rate, Risk Adjustment Factors (RAF), other adjustments	• FY 2021-22 revenue Adjusts for forecasted population mix

* OneCare Connect Medicare rates are not developed from a bid process that uses actual plan data. Staff used most current county benchmark base rate available

** DHCS plan rates uses Rate Development Template (RDT) base data that has a two-year lag

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OneCare Connect Budget Assumptions: Enrollment and Medical Expense

- Enrollment: Applied projected trends for Physician Hospital Consortia (PHC), SRG, HMO and CalOptima Community Network (CCN) networks
  - Considered impact of Medi-Cal redetermination as well as deeming period in projected turning point
- Medical Expense
  - Provider Capitation
    - Medicare component: Based on percent of premium (POP) rates of 34.4% Professional and 45% Facility
    - Medi-Cal component: Based on fixed per member per month (PMPM) rates
  - FFS: Based on actual experience trended through June 2022
    - Applied trend of 1.35% for Hospital Inpatient contract standardization

OneCare Connect Budget Assumptions: Medical Expense (cont.)

- Other adjustments compared to prior year's budget
  - Includes projected increases in Community-Based Adult Services (CBAS), Inpatient, Pharmacy, Mental Health, and Vision expenses
  - Includes projected decreases in LTC, Outpatient Surgery
    - Forecasted ramp-up to normal utilization levels delayed
  - Includes expenses for Medicare supplemental benefits to align with OneCare supplemental benefits

OneCare Connect Challenges

- Challenges
  - CMS applies revenue reductions, including savings targets, quality withhold and sequestration
  - No formal bid process; rates are set at the county FFS benchmark and do not reflect actual plan costs
  - Risk Adjustment Factors reflect difficulties with proper data submission processes
  - Additional costs associated with supplemental benefits
  - Prior to COVID-19 PHE, disenrollment rate greater than enrollment rate
    - Potential risk: CMS regulations penalizes plans for high disenrollment rates

OneCare Connect Initiatives and Actions

- Outsourced CMS data submissions using an external vendor effective October 2019
- Implemented the Primary Care Engagement and Clinical Documentation Integrity Program went into effect on March 2021 for OneCare Connect CCN
- Preparing for CalAIM transition of OneCare Connect membership to OneCare Dual Eligible Special Needs Plan (D-SNP) effective January 2023

OneCare

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OneCare Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	1,463	1,609	1,782
Revenue	$15,950,203	$24,252,182	$25,409,771
Medical Costs	$15,843,761	$22,382,251	$24,233,492
Administrative Expenses	$1,672,376	$1,868,292	$2,153,921
Operating Income/Loss**	**($1,565,934)**	**$1,639**	**($977,642)**
MLR	99.3%	92.3%	95.4%
ALR	10.5%	7.7%	8.5%

* Forecasted as of March 2021

Note: FY 2019-20 Actual and FY 2020-21 Forecast include prior year adjustments

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OneCare Budget Assumptions

- OneCare Revenue Rate Assumptions*

Medicare Part C	Medicare Part D
CMS CY 2021 Monthly Membership Report actuals • Forecasted 0.4% increase to Part C revenue when compared to FY 2021. Combination of base rate and RAF score changes.	CMS CY 2021 Monthly Membership Report actuals • Forecasted 2.5% increase to Part D revenue as compared to FY 2021. Combination of base rate, RAF, other adjustments

- Enrollment projected to increase 8.8% from prior year
- Medical Costs
  - Professional provider capitation: Based on 38.6% POP
  - Includes expenses for approved supplemental benefits
  - Applied trend of 1.35% for Hospital Inpatient contract standardization

* Used most current rate available

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PACE

PACE Program Outlook

Program Update	Timeframe	Budget Assumption
Normal PACE Center activity	January 2022	Assumes incremental enrollment increases and gradual resumption of PACE Center activities through end of June 2022
PACE Alternative Care Settings (ACS)	January 2022	Assumes reenrollment in ACS locations as part of PACE service area expansion
“PACE without Walls” home-based system of care	Began late April 2020	Assumes CMS and DHCS will continue service delivery flexibilities post-pandemic

PACE Budget

	FY 2019-20 Actual	FY 2020-21 Forecast*	FY 2021-22 Budget
Average Monthly Enrollment	380	387	413
Revenue	$37,438,160	$38,878,307	$40,274,039
Medical Costs	$29,648,249	$32,718,478	$36,102,675
Administrative Expenses	$2,204,067	$1,839,770	$2,694,968
Operating Income/Loss	**$5,585,845**	**$4,320,059**	**$1,476,397**
MLR	79.2%	84.2%	89.6%
ALR	5.9%	4.7%	6.7%

* Forecasted as of March 2021

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PACE Budget Assumptions

- PACE Revenue Rate Assumptions*

Medicare Part C	Medicare Part D	Medi-Cal
CMS CY 2021 Monthly Membership Report actuals • Forecasted 9.0% increase to Part C revenue when compared to FY 2021. Primarily driven by positive RAF score improvement.	CMS CY 2021 Monthly Membership Report actuals • Forecasted 2.4% increase to Part D revenue when compared to FY 2021. Primarily driven by base rate increase.	PMPM rates based on CY 2021 rates and reflect a 1.6% decrease. • RDT submission lower reported cost. • RDT credibility increasing annually with additional membership growth.

- Medical costs
  - Based on mix of actual experience and industry benchmarks
  - Reclassifies 96% of some administrative expenses as medical costs to better reflect the actual costs of delivering medical care

* Used most current rate available

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FY 2021-22 Consolidated Budget: Administrative Expenses

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FY 2020-21 Budget vs. FY 2021-22 Budget: Administrative Expenses

	FY 2020-21 Budget	FY 2021-22 Budget	FY 2021-22 Budget vs. FY 2020-21 Budget
Revenue	$3,555,013,609	$3,656,113,456	$101,099,847
Salaries, Wages & Benefits	$95,973,445	$109,536,255	$13,562,809
Non-Salaries	$56,080,906	$59,535,210	$3,454,301
Professional Fees	$4,484,100	$6,112,300	$1,628,200
Purchased Services	$14,873,659	$14,739,002	($134,657)
Printing & Postage	$6,896,270	$6,685,989	($210,281)
Depreciation & Amortization	$7,653,840	$8,386,800	732,960
Other Operating Expenses/Indirect Cost Allocation, Occupancy	$22,173,037	$23,611,119	1,438,079
Total	$152,054,351	$169,071,466	$17,017,111
ALR	4.3%	4.6%	0.3%

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FY 2020-21 Forecast vs. FY 2021-22 Budget: Administrative Expenses

	FY 2020-21 Forecast*	FY 2021-22 Budget	FY 2021-22 Budget vs. FY 2020-21 Forecast
Revenue	$4,046,282,642	$3,656,113,456	($390,169,186)
Salaries, Wages & Benefits	$92,692,765	$109,536,255	$16,843,490
Non-Salaries	$41,874,649	$59,535,210	$17,660,561
Professional Fees	$1,893,241	$6,112,300	$4,219,059
Purchased Services	$11,496,218	$14,739,002	$3,242,784
Printing & Postage	$3,988,943	$6,685,989	$2,697,046
Depreciation & Amortization	$5,939,738	$8,386,800	$2,447,062
Other Operating Expenses/Indirect Cost Allocation, Occupancy	$18,556,509	$23,611,119	$5,054,610
Total	$134,567,414	$169,071,466	$34,504,052
ALR	3.3%	4.6%	1.3%

* Forecasted as of March 2021; Revenue excludes directed payments

Note: FY 2020-21 forecasted figures do not include unfilled open positions

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Administrative Budget: Bridge for FY 2020-21 Forecast vs. FY 2021-22 Budget

G&A Expense	Bridge	Description
Salaries, Wages & Benefits	$16.8M	Existing/vacant positions (53 FTEs) and new positions (41 FTEs) [$9.5M]; Position Reclassification to Admin [$2.4M]; Merit increase (3%) [$2.1M]; Salary adjustment per adoption of updated salary schedule [$1.7M]; Upgrades and retention bonuses [$1.1M]
Professional Fees	$4.2M	Internal audit; Insurance retention changes in policies; Consulting for new initiatives and software applications; Financial and other required audits
Purchased Services	$3.3M	Increase in EDI clearinghouse; Forensic review and prepayment edit; Member interpretation and translation; Advertising; Regulatory compliance services
Printing & Postage	$2.7M	Increase in mailing and processing of member packages and notices; Postage costs; Direct mail campaign; Marketing and outreach materials for members and providers
Other Operating Expenses	$4.9M	Increase in software licenses and maintenance agreements; Insurance policy increase; Building maintenance and supplies; Staff education and development
Depreciation/Amortization, Occupancy & Indirect Allocation	$2.6M	FY 2020-21 and FY 201-22 capital items placed in service
Total G&A	**$34.5M**	

Note: Assumes 7% vacancy factor in FY 2021-22 Budget based on actual experience

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New Position Summary: Administrative and Medical

Administrative	FTE	Description
Operations	29.0	DHCS requirements and information services new initiatives
Financial Affairs	7.0	Financial reporting requirement and procurement reorganization
Executive Office	2.0	Telework monitoring and compensation
Public and Government Affairs	2.0	Member outreach activities
Medical Affairs	1.0	PACE administration
Total	**41.0**	

Medical	FTE	Description
Medical Affairs	18.5	Expansion of the health education program
Operations	4.0	Compliance requirements
Total	**22.5**	

Note: Administrative new positions contribute to the ALR; medical new positions contribute to the MLR

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CalOptima Consolidated Income Statement: Attachment A

Attachment A

CalOptima Fiscal Year 2021-22 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	6,265,845	3,466,738	133,908	9,866,491	181,341	21,382	4,953	2,730	-	10,074,167
Avg Members	522,154	288,895	11,159	822,208	15,112	1,782	413	455	-	839,514
Revenues										
Capitation revenue	$ 1,676,092,280	$ 1,336,597,706	$ 237,188,674	$ 3,249,878,660	$ 339,332,450	$ 25,409,771	$ 40,274,039	$ 1,218,536	$ -	$ 3,656,113,456
Total	$ 1,676,092,280	$ 1,336,597,706	$ 237,188,674	$ 3,249,878,660	$ 339,332,450	$ 25,409,771	$ 40,274,039	$ 1,218,536	$ -	$ 3,656,113,456
Medical Costs										
1 Provider capitation	$ 465,241,785	$ 532,861,966	$ 92,591,963	$ 1,090,695,714	$ 143,668,277	$ 6,785,567	$ -	$ -	$ -	$ 1,241,149,558
2 Claims Payments	$ 590,636,596	$ 449,489,060	$ 68,758,294	$ 1,108,883,950	$ 65,335,099	$ 8,663,244	$ 17,133,053	$ -	$ -	$ 1,200,015,346
3 LTC/Skilled Nursing Facilities	$ 436,617,694	$ 46,351,961	$ 23,887,069	$ 506,856,724	$ 16,976,719	$ -	$ 582,219	$ 158,410	$ -	$ 524,574,072
4 Prescription Drugs	$ 130,255,442	$ 178,661,225	$ 36,604,920	$ 345,521,587	$ 79,340,804	$ 8,226,385	$ 3,994,675	$ -	$ -	$ 437,083,451
5 Case Mgmt & Oth Medical	$ 64,457,231	$ 50,979,798	$ 4,705,889	$ 120,142,918	$ 16,770,208	$ 558,297	$ 14,392,728	$ 722,982	$ -	$ 152,587,132
Total	$ 1,687,208,748	$ 1,258,344,010	$ 226,548,136	$ 3,172,100,893	$ 322,091,108	$ 24,233,492	$ 36,102,675	$ 881,391	$ -	$ 3,555,409,559
MLR	*100.7%*	*94.1%*	*95.5%*	*97.6%*	*94.9%*	*95.4%*	*89.6%*	*72.3%*		*97.2%*
Gross Margin	$ (11,116,467)	$ 78,253,697	$ 10,640,538	$ 77,777,767	$ 17,241,342	$ 1,176,279	$ 4,171,365	$ 337,144	$ -	$ 100,703,897
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 95,901,835	$ 10,543,897	$ 880,620	$ 1,855,157	$ 354,746	$ -	$ 109,536,255
Professional Fees				$ 5,312,550	$ 441,000	$ 350,000	$ 2,000	$ 6,750	$ -	$ 6,112,300
Purchased services				$ 12,183,620	$ 1,303,282	$ 110,000	$ 491,100	$ -	$ 651,000	$ 14,739,002
Printing & Postage				$ 4,605,940	$ 1,657,320	$ 189,869	$ 230,860	$ -	$ 2,000	$ 6,685,989
Depreciation & Amortization				$ 5,910,000	$ -	$ -	$ 4,800	$ -	$ 2,472,000	$ 8,386,800
Other Operating Expenses				$ 21,108,133	$ 252,865	$ 12,350	$ 51,716	$ 43,846	$ 2,330,000	$ 23,798,910
Indirect Cost Allocation, Occupancy Expense				$ (3,593,146)	$ 8,160,631	$ 611,082	$ 59,335	$ 29,307	$ (5,455,000)	$ (187,791)
Total				$ 141,428,932	$ 22,358,995	$ 2,153,921	$ 2,694,968	$ 434,649	$ -	$ 169,071,466
ALR				*4.4%*	*6.6%*	*8.5%*	*6.7%*	*35.7%*		*4.6%*
Operating Income/(Loss)				$ (63,651,165)	$ (5,117,653)	$ (977,642)	$ 1,476,397	$ (97,505)	$ -	$ (68,367,569)
Investment Income										$ 10,000,000
MCO Tax Revenue				$ 168,406,719						$ 168,406,719
MCO Tax Expense				$ (168,406,719)						$ (168,406,719)
CHANGE IN NET ASSETS				$ (63,651,165)	$ (5,117,653)	$ (977,642)	$ 1,476,397	$ (97,505)	$ -	$ (68,367,569)

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Recommended Actions

- Approve CalOptima FY 2021-22 Operating Budget
- Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details
  - Items will be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy

Board Approval Timeline

	Date	Meeting
√	February 18, 2021	Finance and Audit Committee meeting: Present background information on FY 2021-22 Budget Primer
√	April 1, 2021	Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 1
√	May 6, 2021	Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 2
√	May 20, 2021	Finance and Audit Committee meeting: Present FY 2021-22 budgets
√	June 3, 2021	Board of Directors meeting: Present FY 2021-22 budgets
	July 1, 2021	Beginning of Fiscal Year 2021-22

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
24. Consider Approval of the CalOptima Fiscal Year 2021-22 Capital Budget

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2021-22 Capital Budget; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project, which shall be procured in accordance with CalOptima Board-approved policies.

Background
As of March 31, 2021, CalOptima recorded gross capital assets of $103.9 million in the 505 Building, building improvements, furniture, equipment, and information systems. To account for these fixed assets wearing out over time, Staff has charged against the cost of these assets an accumulated depreciation totaling $58.2 million. Staff will record capital assets acquired in FY 2021-22 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years based on components for building improvements.

The resulting net book value of these fixed assets was $45.8 million, as of March 31, 2021. Prior Board-approved capital budgets were $16.2 million in FY 2020-21, and $11.0 million in FY 2019-20.

Pursuant to CalOptima Policies GA.3202: CalOptima Signature Authority, GA.5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure of the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to Management.

Discussion
Management proposes a Capital Budget of $14.7 million for FY 2021-22 within three (3) asset categories summarized in the following table and detailed below:

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Category	Amount	% of Total
1. Information Systems		
Hardware	$3,708,000	25.2%
Software	$6,850,500	46.6%
Professional fees related to implementation	$2,298,500	15.6%
Subtotal	$12,857,000	87.4%
2. 505 Building Improvements	$1,428,000	9.7%
3. PACE	$422,000	2.9%
Total	**$14,707,000**	**100.0%**

1. Information Systems

Information Systems represent nearly $12.9 million or 87.4% of the proposed Capital Budget. This asset category primarily addresses CalOptima's information technology infrastructure needs.

Project Type	Amount	% of Total
Infrastructure	$4,702,000	36.6%
Applications Management	$3,380,000	26.3%
Applications Development	$4,775,000	37.1%
Total	**$12,857,000**	**100.0%**

The Capital Budget includes funding for hardware, software, and professional fees related to the implementation of multiple systems upgrades. More detailed information is provided in Attachment A: Fiscal Year 2021-22 Capital Budget by Project. These upgrades are necessary to support internal operations, and to ensure compliance with state and federal requirements.

2. 505 Building Improvements

505 Building Improvements represent $1.4 million or 9.7% of the proposed Capital Budget. The largest item of $625,000 or 43.8% of the 505 Building capital expenditures is to fund a New Member Services Entrance and Lobby Improvements for Enhanced Security.

Project Type	Amount	% of Total
New Member Services Entrance and Lobby Improvements for Enhanced Security	$625,000	43.8%
Office Suite Renovation and Improvements	$478,000	33.5%
New Roof Membrane Continuation	$100,000	7.0%
Capital Lease for Copiers	$75,000	5.3%
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	$75,000	5.3%
Cooling Tower Continuation	$40,000	2.8%
IDF Room HVAC Unit Replacement	$25,000	1.8%
Recording Studio for Education, Training, Outreach, and Marketing	$10,000	0.7%
Total	**$1,428,000**	**100.0%***

* Total may not add due to rounding

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3. Program for All-Inclusive Care for the Elderly (PACE)
The remaining portion of $422,000 or 2.9% of the proposed Capital Budget is for capital expenditures at the PACE Center.

Project Type	Amount	% of Total
Electronic Storage Expansion	$123,000	29.1%
Interior Light Repairs	$75,000	17.8%
Work Station Renovation	$57,000	13.5%
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	$50,000	11.8%
Conference Room Table Upgrades	$44,000	10.4%
Upgrade Phone Systems to Add Redundancy	$35,000	8.3%
Upgrade Employee Outdoor Patio	$20,000	4.7%
Upgrade Lobby Furniture	$18,000	4.3%
Total	**$422,000**	**100.0%***

* Total may not add due to rounding

Fiscal Impact
Investment in the proposed Capital Budget will reduce CalOptima's investment principal by $14,707,000. Depreciation expenses for the Capital Budget projects are reflected in CalOptima's Operating Budget.

Rationale for Recommendation
The proposed FY 2021-22 Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and improve and upgrade the 505 Building and the PACE Center.

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

Attachments
1. Attachment A: Fiscal Year 2021-22 Capital Budget by Project

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Attachment A

Fiscal Year 2021 - 2022 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Upgrade the Portal Application Load Balancer Appliance	303,000	176,000	81,000	560,000
Office Wireless Network System Upgrade	164,000	84,000	153,000	401,000
Implement Data Operations and Virtualization	165,000	133,000	30,000	328,000
Implement a New Virtual Desktop For Employee Computers To Centralize Support	125,000	125,000	75,000	325,000
Upgrade the Database Disk Storage Equipment	300,000		3,500	303,500
Implement a Test Lab to Support Production Upgrades	300,000			300,000
Encrypt Sensitive Data Within Production Environments	60,000	200,000	40,000	300,000
Upgrade the Citrix Virtual Servers to Support Version	249,000	2,500	7,500	259,000
Upgrade and Expand the Server Monitoring Software	72,000	170,000		242,000
Implement a Solution to Prevent Data Loss Within Cloud Application		140,000	60,000	200,000
Implement the Customer Services Call Recording System		150,000	50,000	200,000
Upgrade the Online Fax System to a Cloud Solution		170,000	15,000	185,000
Increase Virus Protection Licenses for On-Premise Servers		85,000	100,000	185,000
Upgrade the Citrix Disk Storage Equipment	150,000		3,500	153,500
Upgrade and Expand the Network Monitoring Software	140,000			140,000
Implement New Software to Manage Employee Access Accounts			100,000	100,000
Upgrade the Core Systems Development and Test Environments	100,000			100,000
Upgrade the Database Security And Monitoring Software	60,000		25,000	85,000
Upgrade the Corporate Building Server Disk Storage	75,000		3,000	78,000
Upgrade the System Backup Application Disk Storage	75,000			75,000
Computer Network Load Balancer System Upgrade	46,000			46,000
Implement Secure Data Masking for HIPAA Transaction File Sets		36,000		36,000
Upgrade the Email Phishing Software		30,000		30,000
Upgrade the Internet Secure Email Gateway Software	24,000			24,000
Implement New Software to Monitor and Resolve Computer Network Traffic Issues		23,000		23,000
Upgrade and Expand the Computer Network Switches	15,000			15,000
Upgrade the Internet Monitoring Appliance		8,000		8,000
TOTAL INFRASTRUCTURE	**$ 2,423,000**	**$ 1,532,500**	**$ 746,500**	**$ 4,702,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Implement a New Provider Data Management System Including Credentialing And Contract Management		2,250,000	225,000	2,475,000
Upgrade the Core Facets System to Latest Supported Version	329,000	5,000	41,000	375,000
Implement a Provider to Provider eConsult Application (Additional Funding)		200,000	150,000	350,000
Implement Claims Auditing Software		150,000	30,000	180,000
TOTAL APPLICATIONS MANAGEMENT	**$ 329,000**	**$ 2,605,000**	**$ 446,000**	**$ 3,380,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Implement a New Human Capital Management (HCM) System for HR Benefits, Payroll, Employee Performance and Relations, and Recruiting	75,000	500,000	150,000	725,000
Implement and Install Business Continuity Plan Software		400,000	250,000	650,000
Implement a New Service Desk Software to Support, Track, and Monitor Employee Operational Requests	10,000	425,000	85,000	520,000
Implement a New Board Material Software to Streamline Operations		365,000	150,000	515,000
Implement Data Governance Software to Inventory, Label, Categorize, and Define Data Through the Organization's Information Records		400,000	50,000	450,000
Upgrade the Portal Application Audit Log Storage	350,000	50,000		400,000
Upgrade the Caloptima.Org Web Content Management Infrastructure	300,000	15,000	40,000	355,000
Implement a Risk Management Software Application to Support and Manage Compliance and Security Activities		235,000	62,000	297,000
Implement Software to Support Compliance with Americans with Disabilities Act and Web Content Accessibility On Caloptima.Org Website		233,000	59,000	292,000
Upgrade the Accounting AR/AP Software			135,000	135,000
Upgrade the Web Portal Access Management Software	100,000		20,000	120,000
Increase the Portal File System to Support Provider Performance and Member Education Campaigns	100,000	5,000	10,000	115,000
Migrate the Budget Software to Cloud Solution		49,000	38,000	87,000
Implement Customer Service Member Online Chat Services		36,000	12,000	48,000
Implement a New Procurement and Requisition Software Application			35,000	35,000
Upgrade the Data Warehouse Infrastructure	17,000			17,000
Integrate Employees Online Chat Services With the HR Learning Management System for Educational Collaboration			10,000	10,000
Implement Test Automation Software for Web Application Development	4,000			4,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 956,000**	**$ 2,713,000**	**$ 1,106,000**	**$ 4,775,000**

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Attachment A

Fiscal Year 2021 - 2022 Capital Budget by Project

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
New Member Services Entrance and Lobby Improvements for Enhanced Security	530,000		95,000	625,000
Office Suite Renovation and Improvements	443,000		35,000	478,000
New Roof Membrane Continuation	100,000			100,000
Capital Lease for Copiers	75,000			75,000
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	75,000			75,000
Cooling Tower Continuation	40,000			40,000
IDF Room HVAC Unit Replacement	20,000		5,000	25,000
Recording Studio for Education, Training, Outreach, and Marketing	8,000		2,000	10,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,291,000**	**$ -**	**$ 137,000**	**$ 1,428,000**

PACE	EQUIPMENT		PROFESSIONAL FEES	TOTAL CAPITAL
Electronic Storage Expansion	120,000		3,000	$123,000
Interior Light Repairs	75,000			$75,000
Work Station Renovation	57,000			$57,000
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	35,000	5,000	10,000	$50,000
Conference Room Table Upgrades	24,000	20,000		$44,000
Upgrade Phone Systems to Add Redundancy		24,000	11,000	$35,000
Upgrade Employee Outdoor Patio	20,000			$20,000
Upgrade Lobby Furniture	18,000			$18,000
TOTAL PACE	**$ 349,000**	**$ 49,000**	**$ 24,000**	**$ 422,000**

TOTAL FY22 NEW CAPITAL BUDGET	**$ 5,348,000**	**$ 6,899,500**	**$ 2,459,500**	**$ 14,707,000**

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FY 2021-22 Capital Budget

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Overview of Capital Budget

Category	FY 2021-22 Budget	% of Total
Information Systems		
Hardware	$3,708,000	25.2%
Software	$6,850,500	46.6%
Professional fees related to implementation	$2,298,500	15.6%
Subtotal	$12,857,000	87.4%
505 Building Improvements	$1,428,000	9.7%
PACE	$422,000	2.9%
Total	**$14,707,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests

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Information Systems Budget

Capital Project Type	FY 2021-22 Budget
Infrastructure (e.g., Network, Server, Storage, Security)	$4,702,000
Applications Management (e.g., Provider Data Management System, Upgrade Core Facets Systems, Provider to Provider eConsult application, Claims Auditing Software)	$3,380,000
Applications Development (e.g., New Human Capital Management System, Business Continuity Plan Software, Service Desk Software for Employee Operational Requests)	$4,775,000
Total	**$12,857,000**

- Represents nearly 87.4% of total Capital Budget
- Addresses information technology infrastructure needs
- Supports internal operations
- Ensures compliance with state and federal requirements

Note: Project details can be found in Attachment A: Fiscal Year 2021-22 Capital Budget by Project

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505 Building Improvements

Capital Project Type	FY 2021-22 Budget
New Member Services Entrance and Lobby Improvements for Enhanced Security	$625,000
Office Suite Renovation and Improvements	$478,000
New Roof Membrane Continuation	$100,000
Capital Lease for Copiers	$75,000
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	$75,000
Cooling Tower Continuation	$40,000
IDF Room HVAC Unit Replacement	$25,000
Recording Studio for Education, Training, Outreach, and Marketing	$10,000
Total	**$1,428,000**

- Represents 9.7% of total Capital Budget

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PACE Center Budget

Capital Project Type	FY 2021-22 Budget
Electronic Storage Expansion	$123,000
Interior Light Repairs	$75,000
Work Station Renovation	$57,000
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	$50,000
Conference Room Table Upgrades	$44,000
Upgrade Phone Systems to Add Redundancy	$35,000
Upgrade Employee Outdoor Patio	$20,000
Upgrade Lobby Furniture	$18,000
Total	**$422,000**

- Represents 2.9% of total Capital Budget

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Recommended Actions

- Approve the CalOptima FY 2021-22 Capital Budget
- Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project
  - Items will be procured in accordance with CalOptima policies and procedures

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8044: Telework Program, Authorization of the Expansion of the Telework Program, Continuation of the Temporary Telework Program, and Authorization of Related Unbudgeted Expenditures

Contacts

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Recommended Actions

1. Adopt Resolution No. 21-0603-01 Approving Updated CalOptima Policy GA.8044: Telework Program;
2. Authorize continuation of the Temporary Telework Program through December 31, 2021 or twelve (12) weeks beyond the end of the public health emergency as declared by the Orange County Health Care Agency, whichever is later;
3. Authorize the Chief Executive Officer (CEO) to manage CalOptima's Telework Program within the following parameters:
    a. Increase regular telework participation to up 55% of the total budgeted headcount at any given time;
    b. Determine which positions are eligible for regular telework;
    c. Implement a pilot program for partial telework for a period of up to twelve (12) months; and
4. Authorize unbudgeted expenditures of up to $405,000 from unspent budgeted funds for furniture, information services equipment, and other related expenses associated with the Telework Program.

1. Expansion of Telework Program

Background

In November 2008, a telework pilot program was developed. Based on the results, the Board authorized expansion of the Telework Program in February 2010, for up to 125 teleworkers. In June 2013, the program was expanded to up to 180 employees. In April 2015, the Board authorized further expansion to up to 30% of total budgeted headcount at any given time.

In response to the coronavirus public health emergency, the Board ratified implementation of mitigation strategies to slow the transmission of COVID-19 at its April 2, 2020 meeting. These strategies included temporary telework for CalOptima employees. The rapid changes to CalOptima's work structure and allowance of temporary telework alongside regular telework has enabled nearly 90% of CalOptima employees to work remotely either fully or partially during the pandemic.

CalOptima's Telework Program guidelines are described in CalOptima Policy GA.8044: Telework Program. According to the Policy, the total number of employees in telework positions at any point in time may not exceed the maximum number of telework positions authorized by the Board.

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Telework Expansion

As CalOptima proceeds with planning for the return of temporary teleworkers to the office, management recognizes that the pre-COVID workplace and work structure will need to evolve as workers across many sectors of the economy are now seeking more flexible work arrangements. To be competitive in retaining and recruiting top talent, management is recommending an expansion to the Telework Program.

The expansion proposal includes:

1) Increasing the number of regular telework positions from the currently approved level of up to 30% of total budgeted headcount at any given time to up to 55%;
2) Allowing for a pilot program to add a new alternative work schedule—Partial Telework—which will be available for CalOptima employees below the level of department Director and will involve a work schedule of at least three (3) full days at the central worksite and up to two (2) full days at a remote worksite each week; and
3) Redefining "occasional remote work" to allow for infrequent and not regularly scheduled brief periods of work from a remote work location.

CalOptima Policy GA.8044: Telework Program has been revised to reflect the recommended changes to expand CalOptima's Telework Program as more fully outlined in the chart below. Board authorization is requested to continue the temporary telework program through the later of December 31, 2021 or up to twelve (12) weeks beyond the end of the public health emergency as declared by the Orange County Health Care Agency. This timeline will assist management in gradually transitioning employees out of the temporary telework program. The expectation is that employees who are currently temporary teleworkers will return to the office to work. Regular or partial telework will only be granted if: (1) the employee requests such a work structure; (2) the employee and the job responsibilities meet the criteria specified in the Telework Program Policy; and (3) management, in collaboration with HR, approves the work structure.

Discussion

Evaluation of Telework During Temporary Telework

In response to the pandemic, CalOptima management successfully transitioned approximately 700 employees into temporary telework in a short period of time as an employee safety measure while also ensuring continuity in business operations and quality of services to members, providers, and the community. Following this transition, management has been evaluating the effectiveness of telework for positions that may not have been otherwise qualified for telework. Using CalOptima's existing policies, processes, and practices, employees were deployed after signing a Temporary Telework Agreement (Attachment 1), which requires the employee to abide by the terms and requirements of the Telework Program Policy and follow work rules as related to telework, technology capabilities, safety, security, and more.

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Temporary teleworkers were required to set up home office workspaces meeting the requirements of the home office assessment checklist (Attachment 2) and verify the internet speed test (Attachment 3). Every temporary teleworker completed virtual ergonomics training and was offered consultation with CalOptima's ergonomics specialists, if desired.

Temporary teleworkers also agreed to monthly reporting and analyses, at a minimum, relating to his or her performance. (Attachment 4) and the managers of teleworkers were required to monitor teleworkers' productivity and performance consistently, provide timely and specific feedback to teleworkers on a regular basis and provide documentation of goals, performance standards and outcomes for teleworkers to Human Resources upon request. These requirements will continue with the telework expansion and will be closely monitored and audited to ensure compliance. Additionally, CalOptima will continue to be able to identify employee activity through a variety of existing tracking capabilities available to management. For example, network and system access login and logout times, emails, instant messaging, and website activity, building access, and phone usage can all be identified and analyzed, when needed.

When comparing several HR metrics from the year prior to temporary telework (April 7, 2019 – April 6, 2020) with the year of temporary telework (April 7, 2020 – April 6, 2021), we found encouraging results. Work-related injuries decreased 67%, workers' compensation total dollars incurred decreased by 40% and leave time away from work, even with the new COVID-related leave entitlements, decreased 17%. Employee turnover decreased by 41%. Although regular teleworkers account for 30% of the total budgeted headcount, they only accounted for 17% of the turnover between April 2020 – March 2021; the remaining 83% was the result of non-teleworkers separating employment.

Work-Related Injuries	67% decrease
Total Dollars Incurred	40% decrease
Employee Turnover	41% decrease
Leave Use	17% decrease
Employee Relations Cases	57% decrease

When surveyed in December 2020, CalOptima leaders indicated that 80% of teleworkers' performance improved or remained consistent after transitioning to temporary teleworker status. Occasionally, employees or managers discovered that working remotely was not as productive as working from the Central Worksite. In those cases, managers partnered with HR to safely return these employees and/or workgroups to the office.

Expanding Regular Telework Positions

With 449 employees currently in the regular Telework Program, participation is at the Board authorized maximum. Management has identified approximately 300 additional positions that meet the position and job duty eligibility requirements for telework. Combined, these two groups equal approximately 53% of CalOptima's total budgeted headcount. The recommendation to increase the Board authorized regular telework positions to up to 55% allows for a small margin of growth beyond the current telework

positions and positions identified as eligible for telework. Employees will still need to be vetted through the eligibility and approval process to be able to fill one of the regular telework positions.

Allowing Partial Telework

In addition to expanding the number of regular telework positions, management recommends that the Board authorize a pilot of up to 12 months in duration to evaluate a partial telework work schedule. The current policy does not allow employees in senior manager and above positions to work remotely, except in circumstances where the position is hard to fill. If the partial telework pilot is approved, positions below the level of department director may be eligible for partial telework. As part of the pilot program, staff is proposing that the number of partial telework positions not be counted toward the Board's authorized allotment of regular telework positions. This arrangement would allow management to approve partial telework positions based on business needs, including the safe transition of employees back to the office, workspace and parking considerations, and employee demand for regular and partial telework. Instead, positions in the partial telework pilot would be in addition to the proposed 55% of the budgeted total employee headcount at any given time covered by the regular telework program.

To be approved for partial telework under the pilot, an employee would need to meet all the selection and eligibility requirements detailed in CalOptima Policy GA.8044: Telework Program and work at least three (3) full days at the Central Worksite every week.

Staff plans to evaluate the partial telework arrangement at six months and one year after implementation to evaluate its effectiveness. Based on the evaluation results, staff plans to return to the Board with further recommendations.

2. Human Resources Policy GA.8044 Telework Program

Background

On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

The following table lists an existing Human Resources policy that has been updated and is being presented for review and approval.

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

GA.8044 Telework Program

Policy Section	Proposed Change	Rationale	Impact
II.A.	A sentence was added to this paragraph to specify the expectation is for employees to work at the central worksite unless telework is approved by management based on the criteria set forth in the policy	To emphasize that working remotely is not an entitlement, but an optional work arrangement requiring approval and meeting all criteria	Sets expectations with employees that the central worksite is the default work location
II.A.	Added the term "partial" to the sentence defining telework as a workplace arrangement in which an eligible employee works his or her entire (or partial) work schedule away from the central worksite at a remote work location	To add the proposed work arrangement option of partial telework	Adds a third work arrangement, partial telework, to the existing two: regular telework (entire work schedule at the remote worksite) and non-telework (entire work schedule is at the central worksite), and provides a recruitment and retention tool to meet the increased demand for alternate workplace arrangements
II.A.1.	Removed the statement that a partial telework arrangement is not allowed.	To allow for the proposed partial telework option	Adds a third work arrangement, partial telework, to the existing two: regular telework (entire work schedule at the remote worksite) and non-telework (entire work schedule is at the central worksite), and provides a recruitment and retention tool to meet the increased demand for alternate workplace arrangements
II.A.1.	Added a statement that the regular teleworker will not have a dedicated workspace at the central worksite	To align with the current practice of providing dedicated workspaces to only those who are regularly scheduled to work at the central worksite and those in the future who will be regularly scheduled to work full days at the central worksite and full days at the remote worksite each week	Sets the expectation that only a non-dedicated workspace at the central worksite will be provided to those who are not regularly scheduled to work at the central worksite
II.A.2.	Added details regarding partial telework as a twelve (12) month pilot program requiring management approval of a pre-established work schedule split between full days in the central worksite and full days at the remote work location	To identify that partial telework will be a pilot program and require approval of a pre-established consistent work schedule of full days at each work location	Allows sufficient time to determine what impact partial telework may have on meeting workload commitments, attendance, as well as determining whether the new work structure will meet the needs of the department and/or

Policy Section	Proposed Change	Rationale	Impact
			organization and creates accountability, consistency, and transparency of partial teleworkers' work location on any given day, maximizes the work hours of employees by remaining at one work location, and reduces CalOptima risk and expenditures related to workday travel
II.A.2.a.b.c.	Added work schedule requirements for partial teleworkers, including the same three (3) full days at the central worksite each week, and the workday cannot be broken up with part of a day at the central worksite and part of the workday at the remote work location	To create work schedule consistency that coworkers can depend on and to minimize travel related expenses, maximize work hours, and reduce risks resulting from employee travel occurring during the workday	Creates accountability, consistency, and transparency of partial teleworkers' work location on any given day, maximizes the work hours of employees by remaining at one work location, and reduces CalOptima risk and expenditures related to workday travel
II.B.	Clarified the list of reasons a manager may elect not to approve an employee's or department's request to telework	To clearly identify there are situations when a request to telework might not be approved	Sets the expectation that managers will assess business needs, employee performance, and the Telework Program Policy requirements when considering a request to telework
II.C.	Added a statement that there is no limit to the number of partial telework positions	The maximum number of regular telework positions is established by the CalOptima Board of Directors. Allowing management to approve the number of partial telework positions as part of the pilot will provide the flexibility needed to authorize partial telework when policy criteria has been met based on employee demand, business needs, and management discretion	Enables management to fluctuate the number of partial telework positions based on employee demand of both regular and partial telework, business needs, such as performance, productivity, customer service, office and parking space considerations, cost-savings, etc. This will provide the flexibility to help transition temporary teleworkers, as needed, to work in the office.
II.D.	Revised introductory statement to indicate that the criteria listed to be considered for eligibility applies to both regular and partial Telework positions	To specify that the previously listed eligibility criterion now applies to partial telework also	

Policy Section	Proposed Change	Rationale	Impact
II.D.3.	Added items the department will consider when authorizing telework, such as that the telework will contribute to CalOptima objectives while maintaining or improving objectives, efficiency, productivity, service and benefits, not negatively impact external or internal stakeholders, not burden non-teleworkers by being required to handle the teleworker's duties, the teleworker has demonstrated the necessary knowledge, reliability, responsibility, initiative and time management to telework, tasks can be appropriately grouped for partial telework, and resources will not be pulled from the central worksite to the detriment of non-teleworkers	To provide specific items for leaders to consider when approving telework	Assists leaders in making consistent, objective and policy driven decisions to employee requests for regular and partial telework
II.E.1.	Revised definition of "occasional" remote work	To be less restrictive in the interpretation and application of "occasional", while still maintaining that occasional remote work is infrequent and not regularly scheduled work from a remote work location and to clarify that occasional remote work is considered neither a regular nor partial telework position and is not to be attributed to the telework position limits approved by the Board	Allows for an additional flexible work arrangement for occasional remote work to continue on an infrequent and not regularly scheduled basis and to continue not counting occasional remote work as a regular telework position or as a partial telework position
II.F.5.	Added statement regarding benefits for teleworkers living out of state	To identify CalOptima's responsibility of administering benefits to a small number of out-of-state teleworkers	Allows management to provide benefits to out-of-state teleworkers in accordance with applicable employment laws
II.G.1.a.e. & f.	Added statements regarding criteria to be used in selecting a regular or partial teleworker, such as the teleworker being trained to use equipment and software effectively with the appropriate level of	To provide specific items for leaders to consider when approving telework	Assists leaders in making consistent, objective and policy driven decisions to employee requests for regular and partial telework

Policy Section	Proposed Change	Rationale	Impact
	independence for the job duties, all the essential functions of the regular teleworker can be performed remotely, and all the essential functions of the partial teleworker can be allocated between non-telework and telework days to maximize efficiency and resources		
II.G.2.a.	Changed the duration of time an employee must be in good standing from the "last year" to the last "twelve (12) months" and changed "disciplinary action" to "corrective action"	To be more specific on the time frame that will be considered in determining good standing	Provides clarity, consistency, and transparency regarding these criteria
IIG.2.b.	Added a requirement to complete six (6) months continuous employment in the current position before being eligible for telework. In the interest of business needs, the Executive Director of Human Resources can authorize an exception	To closely evaluate employee performance in the new role prior to and as a part of consideration for telework	Prohibits newly promoted or new employees from telework eligibility until after six (6) months in the new role
II.G.2.c. – II.G.2.c.iii.	Redefined position levels eligible to telework from below senior manager level to below director level when the leader's team is comprised of all regular teleworkers or supervision requirements of non-telework staff is met	To expand telework eligibility to include positions up to the associate director level when all criteria has been met and approval granted	Expands telework eligibility to positions at the senior manager level up to associate director level. Directors and executives remain ineligible for regular or partial telework. Leaders up to the associate director level may be eligible for regular telework only when the leader's entire team is comprised of regular teleworkers. Leaders up to the associate director level may be eligible for partial telework if subordinate employees do not need close in-person supervision that can only be provided at the central worksite and there is adequate on-site supervision of the work environment
II.G.2.d.	Revised statement to change the position level ineligibility for telework from senior	To be consistent with the change referenced above, expanding telework eligibility to include positions below the	Directors and executives remain ineligible for regular or partial telework. Senior managers and associate

Policy Section	Proposed Change	Rationale	Impact
	manager level and above to Director level and above	department Director level when all criteria has been met and approval granted	directors may be eligible for telework if all criteria have been met and approval granted.
II.G.2.e.	Added statement that Director level and above are not eligible for partial telework	To be clear that director level and above positions will not be eligible for the partial telework pilot program and enables these leaders to evaluate the pilot program more effectively because they will be working at the central worksite	Sets expectation with employees that high-level leaders will be working from the central worksite and not be eligible for the partial telework pilot program
H.4.	Added a statement that unless extended by the Board of Directors, the partial telework pilot program will terminate at the conclusion of twelve (12) months following the commencement of the partial telework work structure, or an earlier date at the discretion of the CEO	To set expectations with employees that the program is a pilot program only to allow management to evaluate the program's effectiveness. The program can be discontinued at the end of 12 months or at any earlier time by the CEO.. Staff will return to the Board with further recommendations based on the results of the pilot program.	Sets expectations with employees, management, and the Board; requires a thorough evaluation of the program's effectiveness; authorizes the CEO to discontinue sooner, if necessary; and ensures Board oversight and approval to continue beyond the initial period.
II.I.1	Added a statement to the paragraph that the work schedule must be established prior to the start of the work arrangement and must be mutually agreed to by the employee and supervisor	To ensure the department has coverage during core business hours and ensure consistency and transparency regarding the teleworker's work location each day	Requires an employee to obtain management approval of the work schedule prior to the start of telework
II.I.1.c.	Added that coverage during core business hours shall be considered when approving the teleworker's work arrangement	To ensure the department has coverage during core business hours	Allows CalOptima to approve or deny a requested telework schedule based on maintaining adequate coverage during core business hours
II.I.2	Added a requirement that a partial teleworker's scheduled days at the central worksite will be recommended by the employee's supervisor and must be approved by HR	To enable HR to coordinate with facilities to mitigate demands on parking spaces and workspaces by coordinating numbers of employees regularly scheduled at the central worksite on any given day	Requires HR approval of the partial teleworker's scheduled days at the central worksite
II.I.10. & 11.	Revised statement regarding teleworker actions when visiting the office to include a requirement that the teleworker sign-in upon	To account for a teleworker's work location and enable management to identify who is or was in the building in case of an emergency	Requires all teleworkers visiting the central worksite on a normally scheduled telework day to sign-in upon

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Policy Section	Proposed Change	Rationale	Impact
	arrival and reserve a workspace if needed		arrival and reserve a workspace, if needed
II.I.13.a.b.c.	Added statements from the GA.8059 Attendance and Timekeeping policy to be clear when teleworkers are and are not compensated for travel time to and from the remote worksite and central worksite	Included this section from the GA.8059 Attendance and Timekeeping policy as reference as this is a frequent question from teleworkers	Makes clear when a teleworker is compensated for travel time
II.I.15 & 17.	Added & revised statement regarding what is expected of a teleworker when unable to work from the remote worksite for unforeseen reasons and makes clear that the teleworker may be required to report to the central worksite or submit paid time off (PTO) for time not worked	Included as this is a frequently asked question from both Teleworkers and managers	Sets teleworker and supervisor expectations when a teleworker is unable to work from the remote worksite for unforeseen reasons
II.I.18.	Added a statement that teleworkers should keep personal disruptions to a minimum and must obtain pre-approval for use of PTO to attend personal matters	To ensure a productive work environment this statement sets the expectation that the teleworker is responsible for ensuring a productive work environment and that attention to personal matters will not take place while on duty	Sets expectations regarding a productive work environment and requires teleworkers use PTO to attend to personal matters when needed
II.L.8.	Added a statement that expenses incurred because of working a telework schedule will not be reimbursed by CalOptima	To be clear that a remote work schedule, which is voluntary, shifts the burden of telework related expenses from CalOptima to the teleworker	Sets expectation that CalOptima will not reimburse expenses incurred because of working a remote schedule
II.M.1.	Added a requirement that the supervisor will provide the teleworker with written performance expectations and submit to HR for approval prior to commencement of telework	To ensure performance expectations are clear, to allow HR to ensure the chosen expectations are sufficient and measurable, and to hold the supervisor accountable for monitoring the teleworker's performance	Requires supervisors to identify performance expectations, for HR to review and approve the expectations before the teleworker can be deployed for telework
II.N.2.	Added that the manager will document that performance feedback has been shared with the teleworker	To set the expectation that the manager will not only provide documentation of goals and performance standards to HR, but also documentation that performance feedback is also occurring	Requires the manager to provide performance feedback to the teleworker, document the feedback and provide the documentation to HR

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Policy Section	Proposed Change	Rationale	Impact
II.P.2.b.	Added a statement to the section on handling PHI from a remote work location to require that accessing secured and confidential information must not impact the integrity of the information	To ensure the integrity of secured and confidential information, such as PHI is maintained at the remote work location in accordance with applicable privacy policies	Requires teleworkers to follow privacy policies in to protect the integrity of secured and confidential information
II.P.5.	Added statement restricting teleworkers from access or distributing PHI on or through personal devices or using personal devices to access CalOptima information	To protect PHI and business-related information from being improperly accessed	Restricts teleworker's use of personal devices to access or distribute PHI or to access CalOptima business-related information
IX. Glossary – Occasional Remote Work	Revised definition of occasional remote work	To be less restrictive in the interpretation and application of "occasional" while still maintaining that occasional remote work is infrequent and not regularly scheduled work from a remote work location and to clarify that occasional remote work is considered neither a regular nor partial telework position and is not to be attributed to the telework position limits approved by the Board	Allows occasional remote work to continue on an infrequent and not regularly scheduled basis
IX. Glossary – Partial Teleworker	Added the following definition for partial teleworker: an eligible employee who has a pre-established work schedule split between full days at the central worksite, and full days at the remote work location, with three full (3) days per week scheduled at the central worksite	To capture definition of new term for consistent use across HR policies where applicable. To create work schedule consistency that coworkers can depend on and to minimize travel related expenses and risks resulting from employee travel occurring during the workday, partial teleworkers must work three (3) full days per week at the central worksite	Adds a third work arrangement, partial telework, to the existing two: regular telework (entire work schedule at the remote worksite) and non-telework (entire work schedule is at the central worksite), and provides a recruitment and retention tool to meet the increased demand for alternate workplace arrangements
IX. Glossary – Regular Teleworker	Added "regular" to the term "teleworker" and in the definition added the word "entire" to the regularly scheduled work hours	To distinguish the definition of regular teleworker from partial or occasional and to clarify that regular teleworkers work their entire regularly scheduled work hours from a remote work location	Clarifies the definition of regular teleworker

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Policy Section	Proposed Change	Rationale	Impact
Attachment A – Telework Agreement	Added a line with check box to indicate "Regular" and "Partial" Telework option	To use in assessing eligibility for regular or partial telework and in recording and tracking participants in each type of program	Requires employees specify which telework arrangement they are requesting
Attachment A – Telework Agreement	Added a table of the days of the week	To use in assessing the teleworker's requested work schedule	Requires employees requesting partial telework to specify the requested full days in the office and full days at the remote work location
Attachment B - Occasional Remote Work Agreement	Revised definition of occasional remote work to match the proposed definition in the policy	For consistency across telework policy documents	Provides consistency across telework policy documents

3. Authorize Unbudgeted Expenditure

Staff estimates that the equipment (e.g., information services equipment and furniture) and other related costs to expand telework from up to 30% of headcount at any given time to up to 55% at any given time and allow partial telework as proposed is $404,391.

Fiscal Impact
An allocation of up to $405,000 in unspent funds previously budgeted for Other Operating Expenses under the Fiscal Year 2020-21 Operating Budget approved on June 4, 2020, will fund the one-time expenses related to the Telework Program expansion.

Rationale for Recommendation
Offering full and partial teleworking opportunities will enable CalOptima to compete in the competitive labor market for talent and mitigate the need and expense for increased office space and parking. In addition, if the recent decreases in work-related injuries, workers' compensation claims costs, employee turnover, employee relations issues, and employee paid leave use remain, cost savings in these areas may be realized.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 21-0603-01 Approve Updated Human Resources Policy
2. Revised CalOptima Policy GA.8044: Telework Program (redlined and clean) with attachments (redlined and clean)
3. Attachment 1 Temporary Telework Agreement
4. Attachment 2 Telework Home Office Safety Review Checklist
5. Attachment 3 Telework Internet Speed Test Instructions
6. Attachment 4 Teleworker Performance Monitoring Template Guide

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

Continued to a Future Meeting

RESOLUTION NO. 21-0603-01

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

APPROVE UPDATED HUMAN RESOURCES POLICY

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy GA.8044: Telework Program

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 3rd day of June 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	03/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes guidelines for a work structure, where appropriate, when telework is determined to be a viable work option that: 1) permits an eligible employee to perform ~~their~~his/her work from a Remote Work Location~~,~~ unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. CalOptima employees are expected to work at the Central Worksite unless Telework is requested by an employee, a determination is made that the employee and the job functions meet the criteria set forth herein, and the Employee's management approves the request. Telework is a workplace arrangement in which an eligible employee works his or her entire or partial work schedule away from the Central Worksite at a Remote Work Location.

~~A.~~ A ~~,~~Regular Teleworker works his or her entire work schedule away from the Central Worksite at a Remote Work Location unless business needs require otherwise. A Regular

1. ~~A partial teleworking arrangement is not allowed. A~~ Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location. A Regular Teleworker will not have a dedicated workspace at the Central Worksite.

2. CalOptima is testing out a pilot program for a trial period of twelve (12) months to allow for Partial Teleworkers. Employees interested in Partial Telework, who meet the eligibility based on the criteria set forth below, may be conditionally approved for a trial period to allow sufficient time to determine what impact the scheduling change may have on meeting workload commitments, assessing impact on attendance, as well as determining whether the new work structure will meet the needs of the department and/or organization. A Partial Teleworker must obtain management approval for a pre-established work schedule split between full days in the Central Worksite, and full days at the Remote Work Location. A Partial Teleworker's schedule must be consistent with all the following:

   a. Include three (3) full days at the Central Worksite each week.

b. Be consistent from week to week and reflect work at the Central Worksite on the same days each week.

c. A workday cannot be broken up with part of a day at the Central Worksite and part of the workday at the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather~~,~~ an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers and supervisors, at their discretion, may elect not to approve an employee's or department's participation in the Telework Program or discontinue an individual's, group's, or department's participation in the telework program based on business needs, such as change(s) in the employee's or department's work function, employee's non-satisfactory performance, or abuse of or failure to meet the requirements of the telework program.

~~1. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.~~

C. The total number of employees in ~~telework~~Regular Telework positions at any ~~point in~~given time may equal but not exceed the maximum number ~~telework~~of Regular Telework positions as directed by the CalOptima Board of Directors. There is no limit to the number of employees in Partial Telework positions.

D. The following criteria will be used to identify eligible Regular and Partial Telework positions ~~may be identified as follows~~:

1. Human Resources (HR) may designate a position as a ~~telework~~Telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for ~~telework~~Telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for ~~teleworking~~Teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite. In addition, the department leader will consider the following:

a. The telework will contribute to CalOptima's objectives while maintaining or improving program and department objectives, efficiency, productivity, service, and benefits;

b. Telework will not negatively impact customer service for external and internal stakeholders;

c. Employees who remain in the Central Worksite are not burdened by being required to handle the teleworker's regular assignments and job responsibilities;

d. The Teleworker has the necessary knowledge to perform the required job tasks at the Remote Work Location and does not need close supervision or input from others that is available only at the Central Worksite;

e. The Teleworker has a history of reliability and responsibility in reporting to work on time and completing work assignments;

f. The Teleworker is self-directed and consistently demonstrates an ability to establish priorities and effectively manage his/her time;

g. Tasks requiring special equipment, resources, or in-person contact can be grouped and scheduled for non-telework days or accommodated through other means; and

h. Reference materials and resources located at the Central Worksite can be accessed from the Remote Work Location without interfering with co-worker's job performance.

E. Remote Work exception to the Telework policy: ~~When special circumstances require it, an~~An employee's manager has the discretion to allow an employee~~,~~ to work from a Remote Work Location on an occasional basis.

1. Occasional Remote Work is defined as ~~rare,~~ infrequent and not regularly scheduled ~~for~~ brief periods ~~(usually a day or part~~ of work from a ~~day);~~Remote Work Location, with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a ~~telework~~Regular or Partial Telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with ~~PHI,~~Protected Health Information (PHI), establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees ~~to work from a Remote Work Location, to be eligible~~ to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

F. Terms of Employment

~~2.~~1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

~~3.~~2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

~~4. Telework will be voluntary unless specifically stated as a condition of employment.~~

3. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

~~5.~~4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities, and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

5. Teleworkers residing outside the State of California shall be provided the same benefits (or similar benefits if the exact same benefit is unavailable) as Teleworkers residing in California unless the state the Teleworker resides in has a greater or more generous benefit, wherein, CalOptima will provide the greater or more generous benefit to the out-of-state Teleworker.

G. Regular and Partial Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The Teleworker is trained in the use of equipment and software required for the employee to successfully function effectively and with the appropriate level of independence for the job duties.

~~b.~~c. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to~~,~~ the Health Insurance Portability and Accountability Act (HIPAA) regulations.

~~c.~~d. The nature of the work and the employee's job responsibilities do not require daily ~~face-to-face~~in-person contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

~~d.~~e. The nature of the work while at the Remote Work Location is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

f. For Regular Teleworkers, except for the occasional need to come into the Central Worksite for in-person meetings, access to resources or other business-related needs, Regular Teleworkers will be able perform all the essential functions of the employee's job responsibilities remotely.

g. For Partial Teleworkers, the job responsibilities, work assignments, and essential functions of the job can effectively be allocated between non-teleworking days and teleworking days to maximize efficiency and resources.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, ~~with no~~without prior ~~disciplinary~~corrective action in the last ~~year or~~ twelve (12) months, not on a Performance Improvement Plan, and may be ~~scheduled for~~a full-time or part-time employee, and/or may be exempt (salaried) or non-exempt (hourly).

b. Employee must have completed a minimum of six (6) months continuous employment in the current position. Exceptions can be authorized by the Executive Director of Human Resources in the interest of business needs.

c. Based on business considerations and management discretion, ~~supervisors~~for supervisor or manager positions below Director level:

i. If the employee's entire team is comprised of all Regular Teleworkers, the supervisor or manager may be eligible for Regular Telework;

~~i.~~ii. If the employee's team is comprised of Partial Teleworkers and/or Central Worksite employees, the supervisor or manager is not eligible for Regular Telework, but may be eligible for Partial Telework if subordinate employees do not need close in-person supervision that can only be provided at the Central Worksite. Supervisors and managers ~~may be approved for telework only if their entire team teleworks.~~who are eligible for Partial Telework must ensure there is adequate on-site supervision of the work environment, which may require coordination of schedules between supervisors and managers within a department.

~~ii.~~iii. If ~~supervisors and managers have staff that does not telework and/~~the employee's entire team works at the Central Worksite, the supervisor or ~~are~~manager is not eligible for telework~~, they must be present in the office to supervise their non-telework staff.~~ .

~~b.~~d. Regular Telework is not available for ~~senior manager~~Director level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief ~~Operating~~Executive Officer.

~~3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.~~

e. Partial Telework is not available for Director level positions and above.

~~4.~~3. To be eligible to work from a Remote Work Location, the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

H. Termination of Telework Arrangement

1. A Teleworker may elect, at any time, to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

   a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

   b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

   a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities or work performance and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

4. Unless later extended by subsequent Board of Director approval, the Partial Telework pilot program will terminate at the conclusion of twelve (12) months following the commencement of the Partial Telework work structure, or an earlier date at the discretion of the Chief Executive Officer.

I. Work Schedule and Accessibility

1. A Teleworker's work schedule ~~of work hours~~, including days worked at the Central Worksite and days worked at the Remote Work Location, start and end times, breaks, overtime, and deviations from regular work hours~~, should~~ must be established prior to the start of the work arrangement and must be mutually agreed to by the employee and supervisor to ensure the department has coverage during core business hours. Any deviations from the pre-established work schedule must be approved in advance by the Teleworker's ~~manager.~~ supervisor.

   a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, fellow employees, employee morale, functional needs of the department, and/or the progress of individual or team assignments.

   b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to~~:~~ meetings, consultations, presentations, and conferences.

   c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate coverage during core business hours, as well as manager supervision and communication.

2. A Partial Teleworker's scheduled days at the Central Worksite will be recommended by the employee's supervisor and must be approved by Human Resources.

~~2.~~3. The number of hours normally scheduled to work by an employee shall not change because of telework.

~~3.~~4. Employees will not be eligible to participate in both the ~~telework~~Regular or Partial Telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

~~4.~~5. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.

~~5.~~6. An exempt (salaried) Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

~~6.~~7. Non-exempt (hourly) Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

~~7.~~8. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

~~8.~~9. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers~~-~~, and/or members.

~~9.~~10. When ~~visiting~~Regular Teleworkers visit the Central Worksite, ~~a Teleworker will~~they must notify their direct supervisor or ~~alternate~~supervisor's designee of their presence in the office building, including their physical location and tentative length of stay~~.~~, and they must reserve a hotel station, if a workspace is needed, and sign-in upon arrival when arriving in the main lobby.

11. When Partial Teleworkers visit the Central Worksite on their Remote Work Location day, they must notify their direct supervisor or supervisor's designee of their presence in the office building, including their physical location and tentative length of stay, and they must reserve a hotel station, if a workspace is needed, and sign-in upon arrival when arriving in the main lobby.

~~10.~~12. A Teleworker will attend job-related meetings, training sessions, and conferences~~,~~ as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

13. As provided in CalOptima Policy GA.8059: Attendance and Timekeeping, for non-exempt (hourly) employees who work from a Remote Work Location (other than the Central Worksite), commute time may be compensated and included as part of the workday only if all of the following apply:

    a. On a day the employee is scheduled to telework, the employee is required to be onsite at the Central Worksite for meetings, training or other events as determined by the employee's leadership in the middle of the workday; and

    b. The commute to or from the employee's Remote Work Location and CalOptima occurs in the middle of the non-exempt (hourly) employee's workday; and

    c. The employee cannot work from the Central Worksite for the entire workday.

~~11.~~14. During telework hours, a Teleworker must maintain regular contact with the manager, supervisor and co-workers and be reachable via office telephone, mobile phone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

15. If the Teleworker is not able to work at the Remote Location due an unforeseen problem such as a computer issue or internet outage, the Teleworker will immediately notify his or her manager as soon as possible. The manager may assign the Teleworker to other work, request the Employee report to the Central Worksite for the remainder of the day, or require that the Employee submit Paid Time Off (PTO) for time not worked.

~~12.~~16. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. ~~If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.~~

17. If there is an emergency at the Remote Work Location such as a power outage or fire evacuation order, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite or the Teleworker may be required to use PTO for the remainder of the emergency.

18. Teleworkers should keep personal disruptions, such as non-business telephone calls and visitors, to a minimum and must obtain pre-approval from the supervisor for use of PTO to attend to personal matters during work hours.

J. Dependent Care

1. A Teleworker will not act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make arrangements for dependent care ~~arrangements~~ to ensure a productive work environment and permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

K. Deployment Preparation

~~L.~~ Understanding the policies and procedures of telework is an important determinant of success in the telework program.

1. ~~All~~All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. ~~Understanding the policies and procedures of telework is an important determinant of success in the telework program.~~ Teleworkers may be required to complete additional educational or informational programs as deemed needed.

~~M.~~L. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by CalOptima Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a ~~home office~~Home Office.

   c. The ~~home office~~Home Office location and specified workstation ~~and internet access~~ must be in compliance with the EH&S standards and the safety ~~checklists~~requirements.

   d. The employee must maintain an appropriate level of internet connectivity and technological capability as required and defined in the CalOptima Telework Agreement.

   ~~d.~~e. The employee must sign and submit the CalOptima ~~Teleworking~~Telework Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold ~~face-to-face~~in-person business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

    a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office ~~Locations~~locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

    a. CalOptima will provide standard office supplies that can be picked-up from the Central Worksite (i.e., pens, paper, and pencils).

    b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their ~~home office~~Home Office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker. Expenses incurred because of working a telework schedule will not be reimbursed by CalOptima including, but not limited to, the following: costs associated with the use of telephone, internet connection, occupation of the Home Office, and Home Office furniture.

~~N.~~M. Teleworker Performance Management

1. The ~~manager~~Teleworker's supervisor will provide the Teleworker with written performance expectations that are specific, measurable, and attainable and submit to HR for approval prior to the commencement of telework.

~~1.~~2. The supervisor and Teleworker will develop and agree upon ~~any relevant goals and performance guidelines, as well as the~~ the frequency of performance discussions.

~~2.~~3. The manager of the Teleworker shall:

    a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

    b. Provide timely and specific feedback to the Teleworker on a regular basis.

    c. Plan for and use multiple channels to keep the Teleworker informed and ~~up-to-date about~~current with departmental and CalOptima activities.

    d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

~~O.~~N. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards ~~and outcomes for the~~, outcomes, and an indication that feedback on the Teleworker's performance was shared with Teleworker for each of the manager's Teleworkers to HR upon request.

~~P.~~O. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the ~~home office~~Home Office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

    a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work or on duty.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

    a. A Teleworker's property;

    b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

    c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

~~Q.~~P. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location. All Teleworkers and Occasional Remote Workers are expected to

adhere to CalOptima's policies and practices governing the use of technology resources and confidentiality and security of CalOptima information handled in the course of employment.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

   a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

   b. Accessing secured and confidential information, such as PHI, from the Remote Work Location must not impact the integrity of the information in accordance with applicable privacy policies.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite ~~through the use of:~~using binders, folders, or other protective covers.

   ~~a. Binders; or~~

   ~~b. Folders or other protective cover.~~

4. ~~Upon their disposal, a Teleworker shall shred all~~Any PHI documents or files~~. A~~ used by a Teleworker ~~shall transport PHI documents that are taken to the~~at a Remote Work Location ~~and ready for destruction~~shall be transported back to the Central Worksite ~~for shredding.~~to be retained or disposed of in accordance with applicable document retention policies.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies. CalOptima employees shall not access or distribute PHI/Personal Information on or through personal devices nor use personal devices to access CalOptima business information, data, and/or confidential information of any sort.

~~R.~~Q. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management and in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

   a. Maintain the confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC or laptop secure at all times;

   c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

   d. Ensure that passwords or operating instructions are not stored with the computer; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

   a. Loss of a PC or laptop;

   b. Software irregularities indicating possible virus infection; and

   c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include ~~disciplinary~~corrective action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, and with outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

~~S.~~R. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

~~T.~~S. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

~~U.~~T. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must ~~only~~ be used by the Teleworker only and may not be used by other guests or individuals for ~~personal use~~any reason.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

~~V.~~U. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into the Central Worksite from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

~~W.~~V. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

~~X.~~W. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in~~:~~ termination of the employee's telework arrangement and/or ~~disciplinary~~corrective action, up to and including termination of the employee. Certain violations of this Policy, other applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. CalOptima Telework Agreement
B. CalOptima Occasional ~~Off-site~~Remote Work Agreement

V. REFERENCE(S)

A. CalOptima Employee Handbook

B. CalOptima Policy GA.5004: Travel Policy
~~C. CalOptima Policy GA.8000: Glossary of Terms~~
~~D.~~C. CalOptima Policy GA.8020: 9/80 Work Schedule
D. CalOptima Policy GA.8059: Attendance and Timekeeping
E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/12~~Date~~	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
06/06/13	Regular Meeting of the CalOptima Board of Directors
05/01/14	Regular Meeting of the CalOptima Board of Directors
12/03/15	Regular Meeting of the CalOptima Board of Directors
02/01/18	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.8044	Telework Program	Administrative
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative
Revised	TBD	GA.8044	Telework Program	Administrative

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IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the ~~Teleworker's~~ Teleworker's residence.
Occasional Remote Work	Remote work that is infrequent and not regularly scheduled for brief periods with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a Regular or Partial Telework position
Partial Teleworker	An eligible employee who has a pre-established work schedule split between full days at the Central Worksite, and full days at the Remote Work Location, with three full (3) days per week scheduled at the Central Worksite. This is not considered or counted as a Regular Telework position.
Protected Health Information (PHI)	Has the meaning ~~given such term~~ in ~~Section 160.103 of Title~~ 45~~,~~ Code of Federal Regulations~~. Individually~~ Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location or Remote Worksite	The Employee's Home Office or designated pre-approved work location.

Term	Definition
Regular Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location~~,~~ unless business needs require otherwise.

1

Policy:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	03/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes guidelines for a work structure, where appropriate, when telework is determined to be a viable work option that: 1) permits an eligible employee to perform his/her work from a Remote Work Location unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. CalOptima employees are expected to work at the Central Worksite unless Telework is requested by an employee, a determination is made that the employee and the job functions meet the criteria set forth herein, and the Employee's management approves the request. Telework is a workplace arrangement in which an eligible employee works his or her entire or partial work schedule away from the Central Worksite at a Remote Work Location.

1. A Regular Teleworker works his or her entire work schedule away from the Central Worksite at a Remote Work Location unless business needs require otherwise. A Regular Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location. A Regular Teleworker will not have a dedicated workspace at the Central Worksite.

2. CalOptima is testing out a pilot program for a trial period of twelve (12) months to allow for Partial Teleworkers. Employees interested in Partial Telework, who meet the eligibility based on the criteria set forth below, may be conditionally approved for a trial period to allow sufficient time to determine what impact the scheduling change may have on meeting workload commitments, assessing impact on attendance, as well as determining whether the new work structure will meet the needs of the department and/or organization. A Partial Teleworker must obtain management approval for a pre-established work schedule split between full days in the Central Worksite, and full days at the Remote Work Location. A Partial Teleworker's schedule must be consistent with all the following:

   a. Include three (3) full days at the Central Worksite each week.

   b. Be consistent from week to week and reflect work at the Central Worksite on the same days each week.

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c. A workday cannot be broken up with part of a day at the Central Worksite and part of the workday at the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers and supervisors, at their discretion, may elect not to approve an employee's or department's participation in the Telework Program or discontinue an individual's, group's, or department's participation in the telework program based on business needs, such as change(s) in the employee's or department's work function, employee's non-satisfactory performance, or abuse of or failure to meet the requirements of the telework program.

C. The total number of employees in Regular Telework positions at any given time may equal but not exceed the maximum number of Regular Telework positions as directed by the CalOptima Board of Directors. There is no limit to the number of employees in Partial Telework positions.

D. The following criteria will be used to identify eligible Regular and Partial Telework positions:

1. Human Resources (HR) may designate a position as a Telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for Telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for Teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite. In addition, the department leader will consider the following:

a. The telework will contribute to CalOptima's objectives while maintaining or improving program and department objectives, efficiency, productivity, service, and benefits;

b. Telework will not negatively impact customer service for external and internal stakeholders;

c. Employees who remain in the Central Worksite are not burdened by being required to handle the teleworker's regular assignments and job responsibilities;

d. The Teleworker has the necessary knowledge to perform the required job tasks at the Remote Work Location and does not need close supervision or input from others that is available only at the Central Worksite;

e. The Teleworker has a history of reliability and responsibility in reporting to work on time and completing work assignments;

f. The Teleworker is self-directed and consistently demonstrates an ability to establish priorities and effectively manage his/her time;

g. Tasks requiring special equipment, resources, or in-person contact can be grouped and scheduled for non-telework days or accommodated through other means; and

h. Reference materials and resources located at the Central Worksite can be accessed from the Remote Work Location without interfering with co-worker's job performance.

E. Remote Work exception to the Telework policy: An employee's manager has the discretion to allow an employee to work from a Remote Work Location on an occasional basis.

1. Occasional Remote Work is defined as infrequent and not regularly scheduled brief periods of work from a Remote Work Location with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a Regular or Partial Telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with Protected Health Information (PHI), establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

F. Terms of Employment

1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

3. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities, and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

5. Teleworkers residing outside the State of California shall be provided the same benefits (or similar benefits if the exact same benefit is unavailable) as Teleworkers residing in California unless the state the Teleworker resides in has a greater or more generous benefit, wherein, CalOptima will provide the greater or more generous benefit to the out-of-state Teleworker.

G. Regular and Partial Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The Teleworker is trained in the use of equipment and software required for the employee to successfully function effectively and with the appropriate level of independence for the job duties.

c. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) regulations.

d. The nature of the work and the employee's job responsibilities do not require daily in-person contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

e. The nature of the work while at the Remote Work Location is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

f. For Regular Teleworkers, except for the occasional need to come into the Central Worksite for in-person meetings, access to resources or other business-related needs, Regular Teleworkers will be able perform all the essential functions of the employee's job responsibilities remotely.

g. For Partial Teleworkers, the job responsibilities, work assignments, and essential functions of the job can effectively be allocated between non-teleworking days and teleworking days to maximize efficiency and resources.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, without prior corrective action in the last twelve (12) months, not on a Performance Improvement Plan, and may be a full-time or part-time employee, and/or may be exempt (salaried) or non-exempt (hourly).

b. Employee must have completed a minimum of six (6) months continuous employment in the current position. Exceptions can be authorized by the Executive Director of Human Resources in the interest of business needs.

c. Based on business considerations and management discretion, for supervisor or manager positions below Director level:

i. If the employee's entire team is comprised of all Regular Teleworkers, the supervisor or manager may be eligible for Regular Telework;

ii. If the employee's team is comprised of Partial Teleworkers and/or Central Worksite employees, the supervisor or manager is not eligible for Regular Telework, but may be eligible for Partial Telework if subordinate employees do not need close in-person supervision that can only be provided at the Central Worksite. Supervisors and managers who are eligible for Partial Telework must ensure there is adequate on-site supervision of the work environment, which may require coordination of schedules between supervisors and managers within a department.

iii. If the employee's entire team works at the Central Worksite, the supervisor or manager is not eligible for telework.

d. Regular Telework is not available for Director level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Executive Officer.

e. Partial Telework is not available for Director level positions and above.

3. To be eligible to work from a Remote Work Location, the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

H. Termination of Telework Arrangement

1. A Teleworker may elect, at any time, to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities or work performance and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

4. Unless later extended by subsequent Board of Director approval, the Partial Telework pilot program will terminate at the conclusion of twelve (12) months following the commencement of the Partial Telework work structure, or an earlier date at the discretion of the Chief Executive Officer.

I. Work Schedule and Accessibility

1. A Teleworker's work schedule, including days worked at the Central Worksite and days worked at the Remote Work Location, start and end times, breaks, overtime, and deviations from regular work hours must be established prior to the start of the work arrangement and must be mutually agreed to by the employee and supervisor to ensure the department has coverage during core business hours. Any deviations from the pre-established work schedule must be approved in advance by the Teleworker's supervisor.

a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, fellow employees, employee morale, functional needs of the department, and/or the progress of individual or team assignments.

b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to meetings, consultations, presentations, and conferences.

c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate coverage during core business hours, as well as manager supervision and communication.

2. A Partial Teleworker's scheduled days at the Central Worksite will be recommended by the employee's supervisor and must be approved by Human Resources.

3. The number of hours normally scheduled to work by an employee shall not change because of telework.

4. Employees will not be eligible to participate in both the Regular or Partial Telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

5. Before working overtime, a non-exempt(hourly) Teleworker must receive his or her manager's written approval in advance.

6. An exempt (salaried) Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

7. Non-exempt (hourly) Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

8. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

9. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers, and/or members.

10. When Regular Teleworkers visit the Central Worksite, they must notify their direct supervisor or supervisor's designee of their presence in the office building, including their physical location and tentative length of stay, and they must reserve a hotel station, if a workspace is needed, and sign-in upon arrival when arriving in the main lobby.

11. When Partial Teleworkers visit the Central Worksite on their Remote Work Location day, they must notify their direct supervisor or supervisor's designee of their presence in the office building, including their physical location and tentative length of stay, and they must reserve a hotel station, if a workspace is needed, and sign-in upon arrival when arriving in the main lobby.

12. A Teleworker will attend job-related meetings, training sessions, and conferences as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

13. As provided in CalOptima Policy GA.8059: Attendance and Timekeeping, for non-exempt (hourly) employees who work from a Remote Work Location (other than the Central Worksite),

commute time may be compensated and included as part of the workday only if all of the following apply:

a. On a day the employee is scheduled to telework, the employee is required to be onsite at the Central Worksite for meetings, training or other events as determined by the employee's leadership in the middle of the workday; and

b. The commute to or from the employee's Remote Work Location and CalOptima occurs in the middle of the non-exempt (hourly) employee's workday; and

c. The employee cannot work from the Central Worksite for the entire workday.

14. During telework hours, a Teleworker must maintain regular contact with the manager, supervisor and co-workers and be reachable via office telephone, mobile phone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

15. If the Teleworker is not able to work at the Remote Location due an unforeseen problem such as a computer issue or internet outage, the Teleworker will immediately notify his or her manager as soon as possible. The manager may assign the Teleworker to other work, request the Employee report to the Central Worksite for the remainder of the day, or require that the Employee submit Paid Time Off (PTO) for time not worked.

16. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location.

17. If there is an emergency at the Remote Work Location such as a power outage or fire evacuation order, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite or the Teleworker may be required to use PTO for the remainder of the emergency.

18. Teleworkers should keep personal disruptions, such as non-business telephone calls and visitors, to a minimum and must obtain pre-approval from the supervisor for use of PTO to attend to personal matters during work hours.

J. Dependent Care

1. A Teleworker will not act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make arrangements for dependent care to ensure a productive work environment and permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

K. Deployment Preparation

1. Understanding the policies and procedures of telework is an important determinant of success in the telework program. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

L. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

    a. A Teleworker must set up a designated workspace as required by standards set by CalOptima Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

    b. Preferably, this workspace will be a separate room that is designated as a Home Office.

    c. The Home Office location and specified workstation must be in compliance with the EH&S standards and the safety requirements.

    d. The employee must maintain an appropriate level of internet connectivity and technological capability as required and defined in the CalOptima Telework Agreement.

    e. The employee must sign and submit the CalOptima Telework Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold in-person business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

    a. CalOptima will provide advanced notice of any delivery.

    b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

    a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

    a. CalOptima will provide standard office supplies that can be picked-up from the Central Worksite (i.e., pens, paper, and pencils).

    b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH&S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their Home Office site. Individual tax implications, auto and

homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker. Expenses incurred because of working a telework schedule will not be reimbursed by CalOptima including, but not limited to, the following: costs associated with the use of telephone, internet connection, occupation of the Home Office, and Home Office furniture.

M. Teleworker Performance Management

1. The Teleworker's supervisor will provide the Teleworker with written performance expectations that are specific, measurable, and attainable and submit to HR for approval prior to the commencement of telework.

2. The supervisor and Teleworker will develop and agree upon the frequency of performance discussions.

3. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

   c. Plan for and use multiple channels to keep the Teleworker informed and current with departmental and CalOptima activities.

   d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

N. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards, outcomes, and an indication that feedback on the Teleworker's performance was shared with Teleworker for each of the manager's Teleworkers to HR upon request.

O. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the Home Office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

    a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work or on duty.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

    a. A Teleworker's property;

    b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

    c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

P. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location. All Teleworkers and Occasional Remote Workers are expected to adhere to CalOptima's policies and practices governing the use of technology resources and confidentiality and security of CalOptima information handled in the course of employment.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

    a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

    b. Accessing secured and confidential information, such as PHI, from the Remote Work Location must not impact the integrity of the information in accordance with applicable privacy policies.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite using binders, folders, or other protective covers.

4. Any PHI documents or files used by a Teleworker at a Remote Work Location shall be transported back to the Central Worksite to be retained or disposed of in accordance with applicable document retention policies.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies. CalOptima employees shall not access or distribute PHI/Personal Information on or through personal devices nor use personal devices to access CalOptima business information, data, and/or confidential information of any sort.

Q. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management and in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

   a. Maintain the confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC or laptop secure at all times;

   c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

   d. Ensure that passwords or operating instructions are not stored with the computer; and

   e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

   a. Loss of a PC or laptop;

   b. Software irregularities indicating possible virus infection; and

   c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include corrective action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, and with outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

R. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

S. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

T. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must be used by the Teleworker only and may not be used by other guests or individuals for any reason.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

U. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into the Central Worksite from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

V. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

W. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in termination of the employee's telework arrangement and/or corrective action, up to and including termination of the employee. Certain violations of this Policy, other applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. CalOptima Telework Agreement
B. CalOptima Occasional Remote Work Agreement

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.5004: Travel Policy
C. CalOptima Policy GA.8020: 9/80 Work Schedule
D. CalOptima Policy GA.8059: Attendance and Timekeeping
E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/12	Regular Meeting of the CalOptima Board of Directors
06/06/13	Regular Meeting of the CalOptima Board of Directors
05/01/14	Regular Meeting of the CalOptima Board of Directors
12/03/15	Regular Meeting of the CalOptima Board of Directors
02/01/18	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.8044	Telework Program	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative
Revised	TBD	GA.8044	Telework Program	Administrative

1

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the Teleworker's residence.
Occasional Remote Work	Remote work that is infrequent and not regularly scheduled for brief periods with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a Regular or Partial Telework position
Partial Teleworker	An eligible employee who has a pre-established work schedule split between full days at the Central Worksite, and full days at the Remote Work Location, with three full (3) days per week scheduled at the Central Worksite. This is not considered or counted as a Regular Telework position.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location or Remote Worksite	The Employee's Home Office or designated pre-approved work location.
Regular Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.

____CalOptima Telework~~ing~~ Agreement

Name	
Title:	
Department:	
Supervisor/Manager:	

Telework is a workplace arrangement in which eligible CalOptima employees work their entire or partial work schedule away from the central worksite at a remote work ~~Location~~location~~,~~ unless business needs require otherwise. Telework is ~~**not a universal employee benefit or entitlement**, but~~ an alternative method of meeting the work needs of the organization through an innovative and flexible work structure.

I, _____, ("Employee") and CalOptima. mutually agree that the Employee
Print Name
will begin a t~~T~~elework~~ing work~~ arrangement effective on _____ pursuant to this
Date
Agreement (the "Agreement").

1. **Participation:** Employee recognizes that telework~~ing~~ is voluntary and may be reassessed, modified, and may be terminated, by either the employee or CalOptima, with or without cause.

   Other than those duties and obligations expressly imposed on the employee under ~~Human Resource~~CalOptima ~~p~~Policy GA.8044: Telework Program and this A~~a~~greement, the duties, obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. ~~The employee's salary and benefits shall remain unchanged.~~

   The terms "remote work location" or "remote worksite~~place~~" shall mean the employee's residence. The term "central worksite" shall mean the employee's ~~CalOptima's~~ customary CalOptima work address.

2. **Description of the Remote Work Location:**

   a. Employee's regular ~~workplace~~ worksite is at CalOptima in Orange, California. CalOptima and Employee agree that Employee is permitted to work from the following remote work location:

   Employee's residence at _____
   Address City State Zip

   Phone number: _____ _____ _____
   Work Home Cell

3. **Work Schedule:**

   a. Regular Telework _____ Partial Telework _____ (check one)

   b. Employee's work schedule for telework will be:

Days of week Times

c. If Partial Teleworking is requested, Employee's regular work ~~schedule~~ location and work hours ~~for partial work~~ will be:

[Place **X** in appropriate location box for each day of the week]

	Monday	Tuesday	Wednesday	Thursday	Friday
Central Worksite					
Remote Work Location					

** A Partial Teleworker must have a pre-established work schedule of at least three (3) full days every week at the Central Worksite. A workday cannot be broken up with part of a day at the Central Worksite and part of the workday at the Remote Work Location.*

~~c. Days of week Times~~

d. Employee understands and agrees that Employee is expected to work the schedule and hours, and in the location specified above. Deviations from Employee's scheduled hours must be approved in advance by ~~discussed~~the ~~with~~ Employee's supervisor and recorded.

~~3.~~4. **Salary and Benefits**: Employee understands and agrees that this telewor~~king wor~~k arrangement does not affect the Employee's salary or benefits.

~~4.~~5. **Application of CalOptima Policies, Procedures and Rules:**

a. Employee understands and agrees that this telework work arrangement is subject to CalOptima's Telework Program ~~policy~~ Policy GA.8044: Telework Program, as modified from time to time.

b. Employee understands and agrees that the telework work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules, or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules, and standards of conduct.

~~b.~~c. Employee understands and agrees the same precautions governing the treatment of Protected Health Information (PHI), at the Central Worksite shall apply to the remote work location.

~~5.~~6. **Technological Capabilities:** Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

a. In particular, employee is required to:

1) Provide access to an adequate number of grounded power outlets near their work desk and the home internet equipment.

~~2) Provide or purchase a surge protector to guard against damage to equipment~~

~~3)~~2) Provide or purchase *cable internet connection with a minimum transfer speed of 4.5 Mbps download and 1 Mbps upload.

*Note: A wired connection is required. Wireless connection is not permitted.

Note: CalOptima's Information Systems (IS) department does not provide support for any home wireless setup or equipment and requires that there be a wired internet connection within 6 feet from the home internet modem/router to CalOptima's computer equipment.

b. CalOptima will provide equipment as required to be used for work purposes at the remote work location. The equipment may include:
   1) Computer
   2) Monitor(s)
   3) Speaker Bar
   4) Phone headset & enabler
   5) Keyboard & Mouse
   6) VGA Cable
   7) Other equipment as deemed necessary to support the Employee's daily work

~~6.~~7. **Safety and Security:** Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure remote work space within their residence. To enhance Employee well-being and efficiency, the Employee will apply ergonomically appropriate practices in their daily work. The Employee will:

a. Provide or purchase a desk meeting CalOptima requirements, i.e., at least ~~four (4) linear feet~~47 inches ~~in~~ width and at least 36 inches~~"~~ of clear leg room space. The desk must ~~that provides~~ provide adequate space for a PC or laptop, monitor(s), keyboard, mouse, and other work necessities; to perform all of the assigned duties.

b. The work desk will be placed within 6 feet of the home internet equipment.

c. *Provide or purchase storage with a locked drawer to use to secure Protected Health Information (PHI) related documents when not working or when leaving the remote work location or workspace. *Maybe optional if daily work does not deal with PHI or related materials

d. Provide or purchase a first aid kit and a 2A10BC fire extinguisher meeting CalOptima requirements.

e. Provide or purchase a smoke detector to be placed near the work area.

f. Provide or purchase adequate lights/lighting adequate for reading and completing work.

Exceptions: The space below is for documenting any circumstances unique to this telework~~ing~~ situation. "Unique circumstances" include any deviations from the above guidelines that are agreed upon by the teleworker, supervisor, and the Telework Program Coordinator in Human Resources.

Confirmation of Agreement

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this Agreement does not create a contract for employment and does not otherwise change the terms and conditions of employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the Telework~~ing~~ Agreement.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for telework at a remote work site as set forth by my supervisor,

including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

Teleworker: Regular Telework _____ Partial Telework _____ (check one)

~~**Teleworker:**~~

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

Director~~epartment Head~~:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

~~**HR Only**~~
~~Date Received:~~ _____
~~Accepted: ☐ Yes ☐ No~~ _____

Print Name	Signature	Date

Send the original signed form to
Telework Program Coordinator, Human Resources

Keep a copy for your records

CalOptima Telework Agreement

Name	
Title:	
Department:	
Supervisor/Manager:	

Telework is a workplace arrangement in which eligible CalOptima employees work their entire or partial work schedule away from the central worksite at a remote work location unless business needs require otherwise. Telework is an alternative method of meeting the work needs of the organization through an innovative and flexible work structure.

I, _____, ("Employee") and CalOptima. mutually agree that the Employee
Print Name
will begin a telework arrangement effective on _____ pursuant to this Agreement
Date
(the "Agreement").

1. **Participation:** Employee recognizes that telework is voluntary and may be reassessed, modified, and may be terminated, by either the employee or CalOptima, with or without cause.

   Other than those duties and obligations expressly imposed on the employee under CalOptima Policy GA.8044: Telework Program and this Agreement, the duties, obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged.

   The terms "remote work location" or "remote worksite" shall mean the employee's residence. The term "central worksite" shall mean the employee's customary CalOptima work address.

2. **Description of the Remote Work Location:**

   a. Employee's regular worksite is at CalOptima in Orange, California. CalOptima and Employee agree that Employee is permitted to work from the following remote work location:

   Employee's residence at _____
   Address City State Zip

   Phone number: _____ _____ _____
   Work Home Cell

3. **Work Schedule:**

   a. Regular Telework _____ Partial Telework _____ (check one)

   b. Employee's work schedule for telework will be:

   _____ _____
   Days of week Times

c. If Partial Teleworking is requested, Employee's regular work location and work hours will be:

[Place **X** in appropriate location box for each day of the week]

	Monday	Tuesday	Wednesday	Thursday	Friday
Central Worksite					
Remote Work Location					

** A Partial Teleworker must have a pre-established work schedule of at least three (3) full days every week at the Central Worksite. A workday cannot be broken up with part of a day at the Central Worksite and part of the workday at the Remote Work Location.*

d. Employee understands and agrees that Employee is expected to work the schedule and hours, and in the location specified above. Deviations from Employee's scheduled hours must be approved in advance by the Employee's supervisor and recorded.

4. **Salary and Benefits**: Employee understands and agrees that this telework arrangement does not affect the Employee's salary or benefits.

5. **Application of CalOptima Policies, Procedures and Rules:**

a. Employee understands and agrees that this telework work arrangement is subject to CalOptima's Telework Program Policy GA.8044: Telework Program, as modified from time to time.

b. Employee understands and agrees that the telework work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules, or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules, and standards of conduct.

c. Employee understands and agrees the same precautions governing the treatment of Protected Health Information (PHI), at the Central Worksite shall apply to the remote work location.

6. **Technological Capabilities:** Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

a. In particular, employee is required to:

1) Provide access to an adequate number of grounded power outlets near their work desk and the home internet equipment.

2) Provide or purchase *cable internet connection with a minimum transfer speed of 4.5 Mbps download and 1 Mbps upload.

*Note: A wired connection is required. Wireless connection is not permitted.

Note: CalOptima's Information Systems (IS) department does not provide support for any home wireless setup or equipment and requires that there be a wired internet connection within 6 feet from the home internet modem/router to CalOptima's computer equipment.

b. CalOptima will provide equipment as required to be used for work purposes at the remote work location. The equipment may include:
   1) Computer
   2) Monitor(s)
   3) Speaker Bar
   4) Phone headset & enabler
   5) Keyboard & Mouse
   6) VGA Cable
   7) Other equipment as deemed necessary to support the Employee's daily work

7. **Safety and Security:** Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure remote work space within their residence. To enhance Employee well-being and efficiency, the Employee will apply ergonomically appropriate practices in their daily work. The Employee will:

   a. Provide or purchase a desk meeting CalOptima requirements, i.e., at least 47 inches in width and at least 36 inches of clear leg room space. The desk must provide adequate space for a PC or laptop, monitor(s), keyboard, mouse, and other work necessities; to perform all of the assigned duties.

   b. The work desk will be placed within 6 feet of the home internet equipment.

   c. *Provide or purchase storage with a locked drawer to use to secure Protected Health Information (PHI) related documents when not working or when leaving the remote work location or workspace. *Maybe optional if daily work does not deal with PHI or related materials

   d. Provide or purchase a first aid kit and a 2A10BC fire extinguisher meeting CalOptima requirements.

   e. Provide or purchase a smoke detector to be placed near the work area.

   f. Provide or purchase adequate lights/lighting adequate for reading and completing work.

Exceptions: The space below is for documenting any circumstances unique to this telework situation. "Unique circumstances" include any deviations from the above guidelines that are agreed upon by the teleworker, supervisor, and the Telework Program Coordinator in Human Resources.

Confirmation of Agreement

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this Agreement does not create a contract for employment and does not otherwise change the terms and conditions of employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the Telework Agreement.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for telework at a remote work site as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima Telework Agreement

Teleworker: Regular Telework _____ Partial Telework _____ (check one)

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

Director:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

Print Name	Signature	Date

Send the original signed form to
Telework Program Coordinator, Human Resources
Keep a copy for your records

CalOptima Occasional ~~Off-Site~~Remote Work

Name:	
Title:	
Department:	
Supervisor/Manager:	

CalOptima supports alternative work arrangements. One arrangement is an opportunity, when appropriate, for an employee to occasionally work off-site, away from the CalOptima central worksite. "Occasional" is defined as infrequent and not regularly scheduled, for brief periods with no specific or implied expectation from an employee that he or she will be allowed to work from a remote work location routinely. This is not considered or counted as a telework position. This privilege is voluntary and may be terminated at any time by the employee or manager. ~~This is not a universal employee benefit or entitlement, but rather a voluntary alternative method of meeting the work needs of the organization through a flexible work structure.~~

I_____, ("Employee") and CalOptima, mutually agree that the
Print Name

~~pursuant to this Occasional Off-site~~ E~~e~~mployee is eligible to work at a Remote Work Location~~,~~ occasionally, commencing on _____
Date

pursuant to this Occasional ~~Off-Site~~Remote Work Agreement (the "Agreement"). This arrangement is defined in CalOptima Policy~~,~~ GA.8044: Telework Program. ~~It states that, "~~An E~~e~~mployee's manager has the discretion to allow an E~~e~~mployee to work from a Remote Work Location on an occasional basis.~~When special circumstances require it, an employee's manager has the discretion to allow an employee to work from a Remote Work Location on an occasional basis."~~

~~"Occasional" is defined as average of one (1) day or less of remote work per week rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day, with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position. This privilege is voluntary and may be terminated at any time by the employee or manager.~~

Participation:

Employee recognizes that occasional off-site work is voluntary. ~~and at the Employee's discretion.~~ The occasional off-site work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of e~~E~~mployee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Definitions:

a. The terms and definitions in this Agreement shall have the same meaning as the terms and definitions contained in CalOptima Policy GA.8044: Telework Program.

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Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA.8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI~~,~~ security of CalOptima assets, etc.

b. Employee understands and agrees that the occasional off-site work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this Agreement does not create a contract for employment and does not otherwise change the terms and conditions of my at-will employment that applies to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the occasional off-site work agreement or occasional off-site work arrangement and/or my employment, with or without notice, and with or without cause. I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for occasional off-site work as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

~~RECEIVED BY HUMAN RESOURCES:~~

RECEIVED BY HUMAN RESOURCES:

Print Name	Signature	Date

~~Print Name~~ ~~Signature~~ ~~Date~~

Send the original signed form to
Telework Program Coordinator, Human Resources

Keep a copy for your records

CalOptima Occasional Remote Work Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	

CalOptima supports alternative work arrangements. One arrangement is an opportunity, when appropriate, for an employee to occasionally work off-site, away from the CalOptima central worksite. "Occasional" is defined as infrequent and not regularly scheduled, for brief periods with no specific or implied expectation from an employee that he or she will be allowed to work from a remote work location routinely. This is not considered or counted as a telework position. This privilege is voluntary and may be terminated at any time by the employee or manager.

I_____, ("Employee") and CalOptima, mutually agree that the

Print Name

Employee is eligible to work at a Remote Work Location occasionally, commencing on _____

Date

pursuant to this Occasional Remote Work Agreement (the "Agreement"). This arrangement is defined in CalOptima Policy GA.8044: Telework Program. An Employee's manager has the discretion to allow an Employee to work from a Remote Work Location on an occasional basis.

Participation:

Employee recognizes that occasional off-site work is voluntary. The occasional off-site work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Definitions:

a. The terms and definitions in this Agreement shall have the same meaning as the terms and definitions contained in CalOptima Policy GA.8044: Telework Program.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA.8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, security of CalOptima assets, etc.

b. Employee understands and agrees that the occasional off-site work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this Agreement does not create a contract for employment and does not otherwise change the terms and conditions of my at-will employment that applies to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the occasional off-site work agreement or occasional off-site work arrangement and/or my employment, with or without notice, and with or without cause. I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for occasional off-site work as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

RECEIVED BY HUMAN RESOURCES:

Print Name	Signature	Date

Send the original signed form to
Telework Program Coordinator, Human Resources

Keep a copy for your records

CalOptima Temporary Telework Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	
Reason for Request:	☐ **Health conditions resulting in a higher risk** ☐ **Direct exposure to individual with COVID-19** ☐ **Suspected exposure to individual with COVID-19** ☐ **Caring for family member with COVID-19** ☐ **Quarantine order by government entity** ☐ **Minor illness or influence/cold-like illness** ☐ **Childcare as a result of school closure** ☐**Specify school district:** _____ ☐**School closure dates:** _____ ☐ **Travel to/from particular locations with known outbreaks** ☐ **Other: Please specify** _____
Temporary Telework Start Date:	
Anticipated Return Date:	

CalOptima recognizes the unique circumstances surrounding the current COVID-19 pandemic and would like to support alternative work arrangements, where feasible, to help protect CalOptima employees and prevent the further spread of the virus. A voluntary temporary telework arrangement is being made available as an alternative method of meeting the work needs of the organization through a flexible work structure for positions where the essential functions of the job can be performed off-site. This temporary telework agreement will commence once approved by the Human Resources Department, and the termination date will be evaluated weekly based on the conditions and circumstances surrounding COVID-19. You may need to take PTO or unpaid leave if you cannot come to the Office, but are either not yet approved for temporary telework or do not yet have the necessary equipment to perform the essential functions of your job position. Please maintain regular contact with your management regarding your attendance, and HR regarding protected leave and/or reasonable accommodations.

I _____, ("Employee") and CalOptima, mutually agree that the
Print Name

Employee is eligible to work at a Remote Work Location, on a temporary basis, commencing on the date approved by HR below pursuant to this Temporary Telework.
Work Agreement (the "Agreement"). This is not considered or counted as a permanent telework position and will only be granted for the amount of time necessary. This privilege is voluntary, temporary and may be terminated at any time by CalOptima, the employee or manager.

Participation:

CalOptima plays a vital role in the community as a resource for care, information, and support. Our focus is to enable our employees to manage the community response and to serve the needs of CalOptima members, while also taking care of our own employees. Employee recognizes that the temporary telework option is voluntary and at the Employee's discretion. This work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Approval of the temporary telework arrangement will be made based on an evaluation of the appropriateness of your position to work from home, the resources available to enable you to work, business priorities, and staffing concerns. Business continuity for critical areas is our utmost priority to ensure CalOptima is providing excellent services to our members and responding in a timely manner to all inquiries and regulatory requirements.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA. 8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI-security of CalOptima assets, dependent care, etc.
b. Employee understands and agrees that the temporary telework arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site, with particular sensitivity to any protected health information in written or oral form. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for temporary telework as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima may terminate this agreement at any time, with or without notice.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

Print Name	Signature	Date

CalOptima
A Public Agency
Better. Together.

ACTION REQUIRED

Telework Home Office Safety Checklist
Review

Name:		**Title:**	
Department:		**Supervisor:**	
Deployment Date:		**Completion Date:**	

The following **safety review** checklist must be completed for any in-home telework site upon request. All items must be evaluated by the employee as being satisfactory (Yes), in order to continue to participate in the Telework Program. Items on the list shall be installed and maintained in accordance with the CalOptima Telework Program Policy.

I. Electrical	**Yes**	**No**
A. All electrical outlets in the work area are permanent in nature and properly grounded. (Test outlets by using a Surge Protector with a "Grounded" light. If green light is illuminated the outlet is properly grounded)	○	○
B. There are an adequate number of electrical outlets to support equipment in the work area.	○	○
C. Electrical cords are not frayed or otherwise damaged.	○	○
D. Extension cords are not being used as a permanent source of electricity.	○	○
E. Electrical equipment and tools are properly maintained.	○	○
F. Computers, peripheral equipment, and fax machines are connected to surge protectors to guard against damage from power surges.	○	○

II. Fire Protection	**Yes**	**No**
A. Smoke Detector		
1. There is a smoke detector placed in a location near the work area and any equipment used to support teleworking.	○	○
2. Underwriter's Laboratory (UL) and/or the State Fire Marshal approve the smoke detector, and it has a function test mechanism.	○	○
3. Smoke detector(s) have been tested at the time of installation and will continue to be tested on a monthly basis.	○	○
B. Fire Extinguisher		
1. There is a 2A10BC fire extinguisher located on site. (No single fire extinguisher is effective for ALL types of fires. This recommended extinguisher is suitable for home use and your home office.)	○	○

B. Fire Extinguisher (cont.)

2. The fire extinguisher is fully charged.	☐	☐
3. The fire extinguisher is within 10 feet of the electronic teleworking equipment and easily accessible to the teleworker.	☐	☐

III. Emergency Procedures	**Yes**	**No**
A. There is an evacuation plan. (http://www.redcross.org/prepare/location/home-family/plan)	☐	☐
B. There is more than one way out of the work area (e.g., doors/ windows).	☐	☐
C. A first aid kit is on site.	☐	☐

IV. Environment	**Yes**	**No**
A. The work area is free of tripping hazards and is uncluttered.	☐	☐
B. All company assets including, but not limited to, computers, phones as well as any other allocated property is secure, adequately supported and free from the danger of falling and is kept in a clean environment free of debris and other items/entities that may cause harm.	☐	☐
C. The work area has adequate lighting. (Enough lighting so you can easily read printed, handwritten or displayed material but are not inhibited by too much light or glare)	☐	☐
D. Potentially hazardous chemicals are not stored in, or around, the work area.	☐	☐

V. Work Station Arrangement		
A. Positioning When Seated	**Yes**	**No**
1. Are your forearms and wrists parallel to the floor and upper arms resting at your sides when positioned at the keyboard or work surface?	☐	☐
2. Are your thighs parallel to the floor?	☐	☐
3. Are your feet supported?	☐	☐
4. Is there at least 2 inches of clearance between your thighs and the working surface?	☐	☐
5. Is there space, approximately the size of a fist, between the edge of the seatpan and the back of your knees?	☐	☐
6. Is the top of the monitor at a comfortable height *(i.e. no tilting of the head back or downward)*?	☐	☐
7. Is the monitor screen at a comfortable distance from your eyes when in use *(i.e. you don't have to lean forward or backward to see the text on the screen)*?	☐	☐
8. Does your head and neck rest in a neutral position *(i.e. facing forward, chin slightly down, shoulders relaxed)*?	☐	☐

Telework Home Office Safety Checklist
Review

B. Chair Adjustment	Yes	No
1. Is the height of the chair adjusted to allow you to sit in a neutral position (see your safety officer for a definition of this position)?	○	○
2. Is the backrest of your chair supporting the curve of your lower back so that your spine is slightly arched?	○	○
C. Foot Support	**Yes**	**No**
1. Are your feet comfortably on the floor or a footrest?	○	○
2. If a footrest is used, does it allow you to sit in a correct neutral position at your work station? (skip to D if a footrest is not used)	○	○
3. Is the footrest non-restrictive to allow for leg movement and easily removable?	○	○
D. Video Display Terminal (VDT) Screen/ Monitor	**Yes**	**No**
1. Is your monitor placed to avoid glare caused by light sources?	○	○
2. Is your screen angle and/or brightness and contrast controls adjusted to reduce glare?	○	○
3. Is your screen clean and free from dust and smudges?	○	○
4. Is your screen adjusted for good image contrast and brightness?	○	○
E. Workspace Arrangement	**Yes**	**No**
1. Are materials and equipment accessed and/or used frequently typically positioned/placed within 16” of reach (neutral/comfort zone)?	○	○
2. Are materials and equipment accessed and/or used less frequently typically positioned/placed within 16” to 24” of reach (secondary zone)?	○	○
3. Are frequently used materials/equipment positioned so harmful postures and motions are eliminated?	○	○
4. Are documents placed in the same visual plane as the screen face to reduce back and forth neck motions?	○	○
5. Are most of your reaching motions below shoulder height and/or above knee height?	○	○

Caution: “No” responses to any questions may indicate a potential problem with your in-home workspace arrangement and may prevent continued participation in the Telework Program.

VI. Acknowledgement

CalOptima is ultimately responsible for ensuring that employees have a safe work environment under Cal-OSHA (C.L.C. Section 6401.7(a)2), In addition to the initial and annual employee review of the checklist, CalOptima may require an on-site safety inspection of a teleworker's home office space. When warranted, CalOptima will provide 48-hour notice to the employee except in the case of an emergency.

A home office safety review will be required on an annual basis.

By printing my name below, I confirm that my home office meets all the above requirements in the Home Safety Checklist.

_____	_____
Employee's Name	Date
_____	_____
Reviewed by EH&S	Date

RETURN THE COMPLETED FORM TO THE MANAGER, ENVIRONMENTAL HEALTH & SAFETY.

MUST BE RECEIVED BY REQUESTED DATE AND APPROVED BY EH&S IN ORDER TO CONTINUE TO WORK AT THIS IN-HOME SITE.

ACTION REQUIRED

CalOptima requires a computer cable internet connection to the modem at your Telework location with a minimum transfer speed of 4.5 Mbps download and 1 Mbps upload.

The following pages contain directions to perform a download and upload speed test of your internet service. Please select only one Speed Test Site to perform the speed test. Multiple sites are listed in this document in the event that one site does not operate properly.

Make sure to perform the Speed Test before launching VPN.

INTERNET SPEED TEST RESULTS

Name: _____

Internet Service Provider: _____ Speed Test Site Used: #_____

Download Speed: _____

Upload Speed: _____

Insert screen shot of results:

Fill in your results and email to
Telework Program Coordinator, Human Resources.

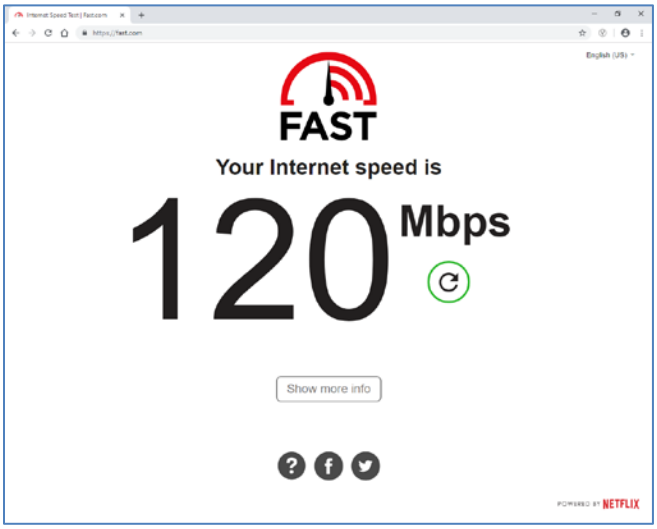
Testing Your Internet Speed

Multiple speed test sites are available for performing home Internet speed testing.

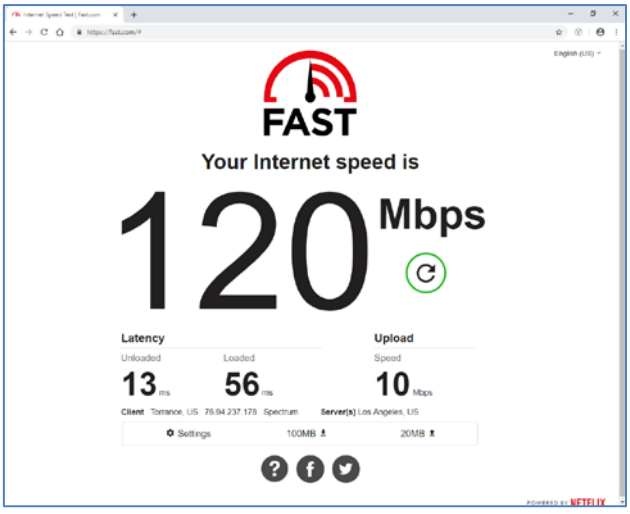
<u>Only one speed test is required. Select from any the below sites to perform the test</u>.

SPEED TEST SITE #1

Open your internet browser and go to: www.fast.com



Give it a minute to run. Once the download speed is shown, select **Show more info**.



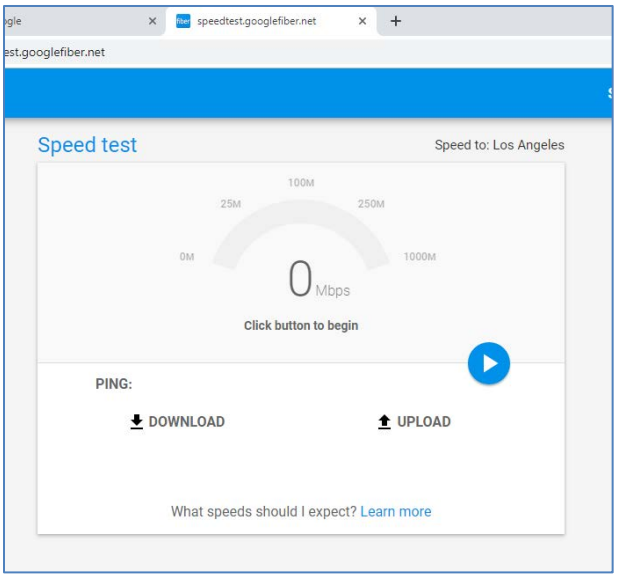
From your keyboard, perform a screen print of the speed test results by depressing the **Prt Scn** or **Ctrl** and **PrtScr** keys.

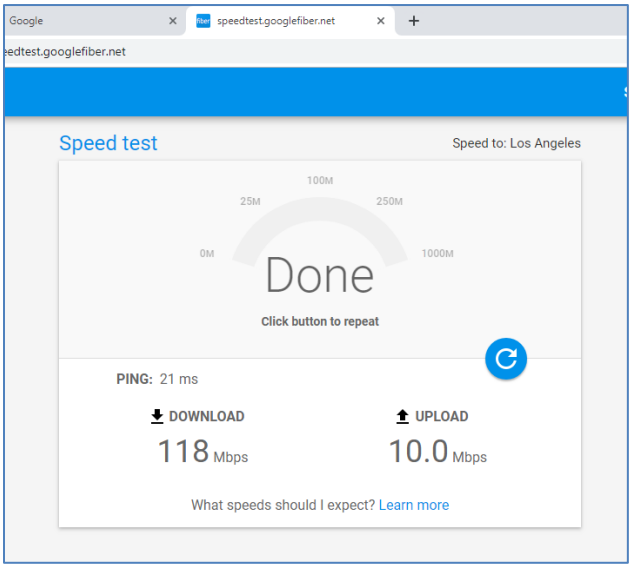
Paste the results image on this document cover page or in a Word document and send it to the Telework Program Coordinator in Human Resources.

SPEED TEST SITE #2

Open your internet browser and go to: http://speedtest.googlefiber.net/

Click the **play** button to start the test and give it a minute to run.



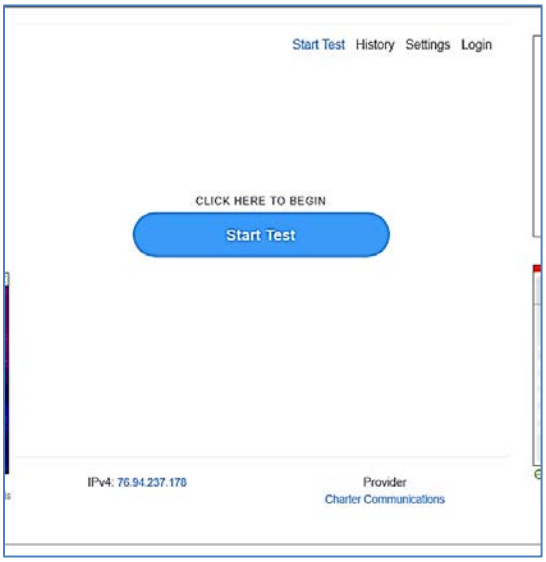


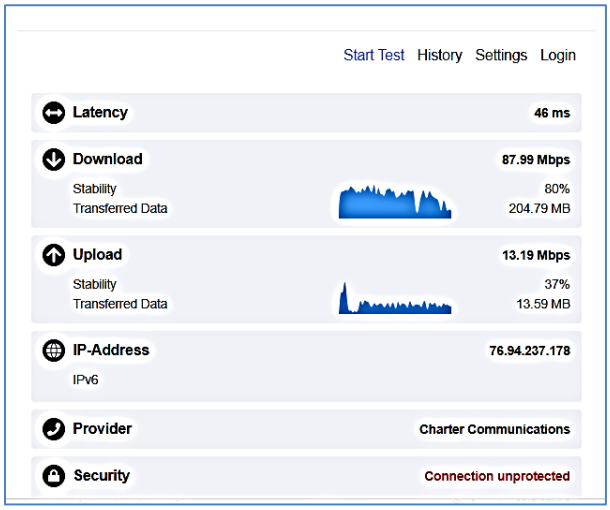
From your keyboard, perform a screen print of the speed test results by depressing the **Prt Scn** or **Ctrl** and **PrtScr** keys. Paste the results image on this document cover page or in a Word document and send it to the Telework Program Coordinator in Human Resources.

SPEED TEST SITE #3

Open your internet browser and go to: www.speedcheck.org

Click the **Start Test** button to start the test and give it a minute to run.



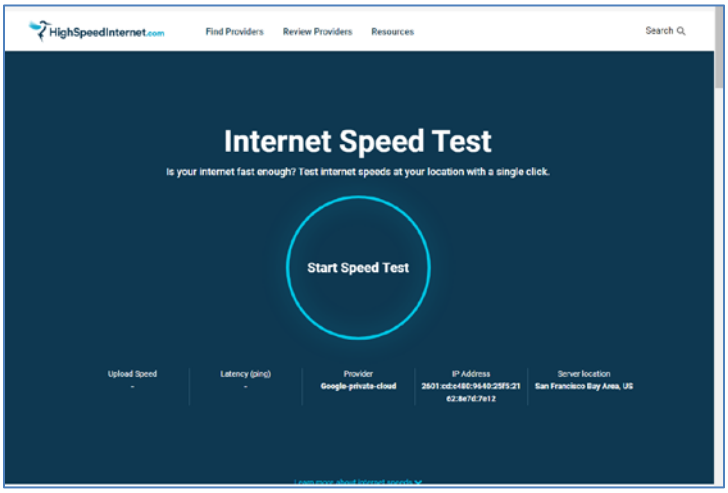


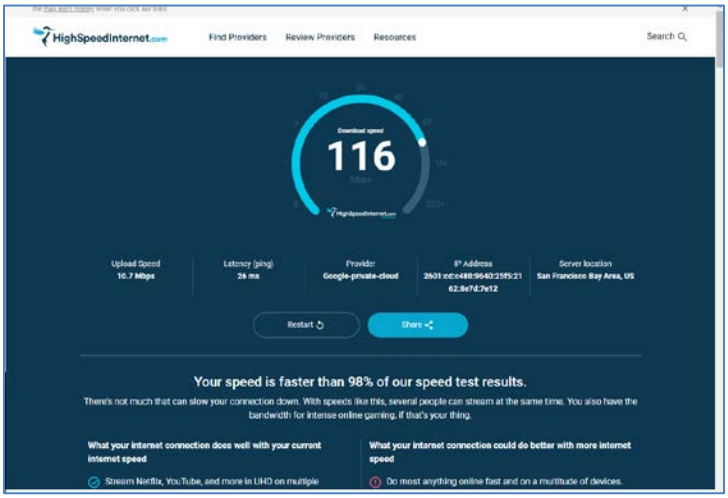
From your keyboard, perform a screen print of the speed test results by depressing the **Prt Scn** or **Ctrl** and **PrtScr** keys. Paste the results image on this document cover page or in a Word document and send it to the Telework Program Coordinator in Human Resources.

SPEED TEST SITE #4

Open your internet browser and go to: www.highspeedinternet.com/tools/speed-test

Click the **Start Speed Test** button to start the test and give it a minute to run.





From your keyboard, perform a screen print of the speed test results by depressing the **Prt Scn** or **Ctrl** and **PrtScr** keys. Paste the results image on this document cover page or in a Word document and send it to the Telework Program Coordinator in Human Resources.

Teleworker Performance Monitoring

The supervisor of each telework participant retains responsibility for the daily supervision and management of the Teleworker and his/her productivity and performance. The supervisor and Teleworker will discuss goals and performance guidelines, as well as the frequency of performance discussions. Best practices for the supervisor of a Teleworker include:

- Define and agree upon work performance standards and goals that are measurable and methods to monitor performance.
- Establish and discuss processes to oversee and support the Teleworker's job performance.
- Monitor work and productivity daily.
- Regularly produce and review performance using a monitoring tool with standards.
- Provide specific performance feedback, both positive and corrective, on a regular basis.

As outlined in CalOptima's Telework Program policy, each supervisor of one or more Teleworkers will provide documentation of goals, performance standards and outcomes for their Teleworkers to Human Resources upon request. The use of a standardized report template is encouraged.

A performance monitoring report tool for a Teleworker contains at a minimum:

- *Employee Name*
- *Report Period*
- *Measure of*: (1 or more)
  - *Quality* (Effectiveness) – degree or grade of excellence; degree to which objectives are achieved; ability to produce desired result
  - *Productivity* (Efficiency) – the rate at which items are produced or work is completed; ability to produce work product without wasting materials, time or resources
  - *Timeliness* – work produced on time according to agreed-upon deliverable time frame
- *Indication of Measurement Standards* – defined criteria to meet a set level of performance; establishes expectations between supervisor and Teleworker
- *Notation with a date indicting the measures and outcomes were shared with Teleworker* (minimum once per month)

Guide to Completing the Report Template

The following is a guide to using the standardized performance report template.

Include:

- Employee Name
- Reviewer Name
- Report Period (review dates - week, month or quarter)
- ELEMENT (1 or more)
  - An activity or key component of work to be monitored
- GENERAL MEASURE
  - The attribute of the element to be measured
    - ✓ *Quality* (Effectiveness) – degree or grade of excellence; degree to which objectives are achieved; ability to produce desired result
    - ✓ *Productivity* (Efficiency) – the rate at which items are produced or work is completed; ability to produce work product without wasting materials, time or resources
    - ✓ *Timeliness* – work produced on time according to agreed-upon deliverable schedule
- SPECIFIC MEASURES
  - The goal or level of accomplishment for each element
- STANDARDS
  - The specific criteria or outcomes that meet a set level of performance
    - ✓ *Expectations Not Met*
    - ✓ *Expectations Met*
    - ✓ *Expectations Exceeded*
- FEEDBACK SOURCE
  - The reports or tools used to collect data on performance
- TELEWORKER PERFORMANCE RESULTS/FEEDBACK
  - Analysis of output or indicators of accomplishments; statements regarding performance of an element; maybe used as a basis for improvement
- REVIEW DATE BOX
  - Area with date indicating data shared with and acknowledged by Teleworker

Date Reviewed: _____
Manager: _____
Employee: _____

Teleworker Performance Monitoring

[NAME, TITLE]
[Reviewer]
[Report Period]

EXAMPLES

ELEMENT	GENERAL MEASURES	SPECIFIC MEASURES	STANDARDS			FEEDBACK SOURCE FOR MONITORING	TELEWORKER PERFORMANCE RESULTS / FEEDBACK
			Expectations Not Met	Expectations Met	Expectations Exceeded		
• Recorded Call Audit	• Quality	• Member identification/PHI • ID member issue • Style & Courtesy • Documentation • Resolution of issue • Closing	• <94%	• <95-99%	• <100%	• 10 random calls per month • Engage Recording System • Access Audit Database	• Met Expectations o 97.63%
• Manage Individual Eticket Requests	• Timeliness • Quality	• Provides realistic and agreed upon timeframe for completion of tasks • Average number of defects occurring in production post implementation	• Requests completed behind schedule per Service Level Agreement (SLA) with business • Defects encountered requiring re-work	• Requests completed on time per SLA with business • No defects encountered in production	• Requests completed prior to due date per SLA with business • No defects encountered in production	• Eticket Requests report	• Met Expectations: o processed Eticket requests timely; o no defects encountered in production
• Telephonic Metrics	• Productivity	• Calls per hour	• <7.49	• 7.5-8.69	• >8.7	• CSR Performance by Date Range	• Met expectations o 7.56 calls/hr

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Authorizing Lease Extension Agreement for the Real Property Located at 13300 Garden Grove Boulevard, Garden Grove, California

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into a Lease Extension Agreement for the real property located at 13300 Garden Grove Boulevard, Garden Grove, California to extend its term for ten (10) additional years, through December 31, 2031.

Background
On February 3, 2011, the Board of Directors (Board) authorized the CEO to enter into a Lease, consistent with the terms of the Letter of Intent (LOI) that was subsequently executed on February 17, 2011, for the real property located at 13300 Garden Grove Boulevard, Garden Grove, California. The property is the location of the CalOptima PACE Center and is approximately 23,650 square feet. The current expiration date of the lease agreement is December 31, 2021.

The Board met with real estate consultants, Newmark Knight Frank to consider price and terms for a lease agreement covering the referenced property at its November 19, 2020, and December 3, 2020, meetings. Subsequently, at the Board's Finance and Audit Committee meeting on February 18, 2021, and at the Board's March 4, 2021, meetings, it had further discussions on price and terms of payment with Newmark Knight Frank.

Discussion
Based on Board discussions and negotiations with the landlord, the following Lease Extension Agreement terms are proposed:

- A 10-year extension, effective January 1, 2022, through December 31, 2031, with an option to terminate the agreement after 60 months, at CalOptima's sole discretion with an early termination fee totaling $449,091;
- Rent per square foot up to $2.30 per square foot for the initial extension year, and a three percent (3%) increase each year thereafter;
- A $354,750 tenant improvement credit over a 60-month period; and
- A 5-year extension option at the conclusion of the extension period.

Fiscal Impact
The proposed CalOptima Fiscal Year (FY) 2021-22 Operating Budget pending Board approval incorporated funding for the PACE Center Lease Extension Agreement of approximately $610,000. Management will include expenses related to the recommended lease extension for the periods of July 1, 2022, through December 31, 2031, in future operating budgets.

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Rationale for Recommendation

The recommendation will allow CalOptima to continue operations of the PACE Center at 13300 Garden Grove Boulevard without disruption of services to members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Draft Lease Extension Agreement

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Newmark Knight Frank	18401 Von Karman Avenue, Suite 150	Irvine	CA	92612
Celia S. Kim	4072 Northpark Circle	Irvine	CA	92604
Soon Y. Kim	4072 Northpark Circle	Irvine	CA	92604
Young S. Kim	8581 N. Bedford Motorway	Corona	CA	92883

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LEASE EXTENSION AGREEMENT

This LEASE EXTENSION AGREEMENT ("Agreement") is made and entered into as of the 24th day of May, 2021, by and between Young S. Kim and Soon Y. Kim, as joint tenants (collectively, "Landlord"), and Orange County Health Authority, a public agency doing business as CalOptima ("Tenant").

RECITALS

A. Landlord and Tenant are parties to a certain Single Tenant Triple Net Lease dated April 27, 2011 (the "Lease") concerning 13300 Garden Grove Blvd, Garden Grove, California, as shown in Exhibit A of the Lease and all other improvements thereon (the "Premises"); and

B. Except as expressly set forth in this Agreement, Landlord and Tenant hereby acknowledge, confirm and reaffirm any and all terms and conditions of the Lease, including without limitation, the term thereof and the rent payable thereunder; and

C. Pursuant to Section 2 of the Lease entitled Term and Basic Lease Information, the Primary Term of the Lease is ten (10) years, which will end on December 31, 2021; and

D. Pursuant to Section 33 of the Lease entitled Options to Extend, Landlord granted to Tenant the option to extend the Lease for two (2) periods of five (5) years each, commencing on January 1, 2022 (Commencement Date); and

E. Notwithstanding Section 33 providing for two (2) five (5) year options to extend the Lease, Tenant desires to extend the Lease for a period of ten (10) years (Extended Term), but reserves the right to terminate the Lease after sixty (60) months

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from the Commencement Date of the Extended Term as hereinafter set forth; and

F. Tenant properly and timely exercised its option to extend the Lease, and Landlord and Tenant have agreed to the terms and conditions of the Extended Term as set forth herein.

NOW THEREFORE, in consideration of the mutual covenants and promises contained herein, and pursuant to Section 33 of the Lease, Landlord and Tenant now wish to extend the Lease and adjust the monthly rental payable thereunder as follows:

1. The term of the Lease is hereby extended for one hundred and twenty (120) months commencing on January 1, 2022 and terminating on December 31, 2032, unless earlier terminated or extended as set forth herein or otherwise provided in the Lease.

2. Commencing January 1, 2022 and continuing until December 31, 2022, the monthly rental shall be $2.30 per rental square foot on a triple net basis in accordance with the Lease. Each year thereafter, commencing on January 1st and ending on December 31st, the monthly rental shall increase by three percent (3%) over the year just ended.

3. Tenant shall continue to be responsible for Operating Expenses, Real Estate Taxes and other Occupancy Costs in connection with this Agreement in accordance with the terms of the Lease.

4. Landlord shall provide an allowance for Tenant Improvements ("Tenant Improvement Allowance") in connection with this Agreement in the amount of Fifteen Dollars ($15.00) per rentable square foot. The Tenant Improvement Allowance shall be paid by Landlord by way of credits against the monthly rent otherwise payable by Tenant

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over the first sixty (60) months of the extended term in sixty (60) equal installments. Based on the foregoing, the total Tenant Improvement Allowance of Three Hundred Fifty-Four Thousand, Seven Hundred Fifty Dollars ($354,750) shall be paid by Landlord to Tenant by sixty (60) equal monthly credits of Five Thousand Nine Hundred Twelve and 50/100s Dollars ($5,912.50) against Tenant's monthly rent obligation. Tenant shall be responsible for the construction of all tenant improvements, which construction shall be subject to Landlord's reasonable approval in accordance with the Lease. However, in accordance with Section 7. a. of the Lease, Landlord shall not be entitled to any overhead or supervision fee in connection with the approval or construction of the tenant improvements.

5. In addition to the provision of Section 32.b. of the Lease, Tenant shall have a one-time right to terminate the Lease and this Agreement ("Early Termination Right") upon the giving of written termination notice ("Termination Notice") to Landlord. Said Early Termination Right shall become effective upon the commencement of the sixty-first (61st) month of this Agreement ("Early Termination Date"). To be effective, Tenant must: (i) give the Landlord the Tenant's Termination Notice no less than twelve (12) months prior to the Early Termination Date; and (ii) pay a fee in the amount of Four Hundred Forty-Nine Thousand and Ninety and 72/100 Dollars ($449,090.72) ("Termination Fee") on or before the Early Termination Date. The failure of Tenant to either (i) give timely written Termination Notice or (ii) pay Landlord the Termination Fee in full on or before the Early Termination Date shall render the Early Termination Right

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null and void.

6. Tenant shall have one (1) option to extend the term of this Agreement for a period of sixty (60) months ("Extension Option"). If Tenant elects to exercise its Extension Option, Tenant shall give written notice ("Exercise of Extension Option") to Landlord not more than two hundred seventy (270) days nor less than one hundred eighty (180) days prior to the expiration of this Agreement. Should Tenant elect to exercise its Extension Option, the rent payable during the extended sixty (60) month term shall be set in accordance with the provisions of Section 33. e. of the Lease.

7. All brokerage commissions payable in connection with this Agreement shall be paid by Landlord and shall be paid pursuant to a separate Lease Commission Agreement between Landlord and Newmark of Southern California, Inc. ("Broker").

8. Except as set forth in Paragraphs 1 through 8, above, all other terms and conditions of the Lease shall remain unmodified and in full force and effect.

9. Each individual executing this Agreement warrants that he/she has full authority to execute this Agreement on behalf of the parties upon whose behalf he/she so signs and that this representation is an essential and material provision hereof and shall survive the execution hereof.

10. This Lease Extension may be executed in counterpart and each such counterpart shall be deemed an original instrument.

IN WITNESS HEREOF, Landlord and Tenant have executed this Lease Extension on the date set forth below.

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Dated: May __, 2021

Tenant:

Orange County Health Authority, a public Agency doing business as CalOptima

_____

By: _____

Its: _____

Dated: May__, 2021

Landlord:

_____
Young S. Kim

_____
Soon Y. Kim

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
27. Election of Officers of the Board of Directors for Fiscal Year 2021-22

Contact
Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Action
Elect Board Chair and Vice Chair for terms effective July 1, 2021 through June 30, 2022, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
28. Consider Approval of Modifications to CalOptima Medical Affairs Policies: GG.1102, GG.1301, and GG.1313

Contacts
Emily Fonda, M.D., Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, (714) 246-8549

Recommended Actions
Approve recommended modifications to the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. Policy GG.1102: Experimental and Investigational Service Coverage
2. Policy GG.1301: Comprehensive Case Management Process
3. Policy GG.1313: Coordination of Care for Transplant Members

Background/ Discussion
CalOptima regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima operations.

Below is a description of the impacted policies, followed by a list of substantive changes to each policy, which are reflected in the attached redline. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **Policy GG. 1102: Experimental and Investigational Service Coverage** defines benefit coverage for Experimental and Investigational Services under the CalOptima program. ***Experimental Services*** are drugs, equipment, procedures, or services that are undergoing laboratory or animal studies before testing in humans. ***Investigational Services*** are drugs, equipment, procedures, or services for which laboratory and animal studies have been completed, and for which human studies are in progress but not yet complete. The effectiveness and safety of these services in human subjects have not yet been established, and it is not generally accepted by the medical community in the United States nor is it in widespread general medical usage in the United States. Investigational Services are covered only under certain circumstances, and when authorization is given before the services are delivered.

Policy Section	Proposed Change	Rationale	Impact
II.A	Included language that the policy applies to Members in CalOptima's Whole Child Model.	WCM Members are covered by this policy.	No change from how these services were handled before WCM.

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Policy Section	Proposed Change	Rationale	Impact
II.B.1.e	Added that an Investigational Service must be the lowest cost item that meets the Member's medical needs, and is less costly than all conventional alternatives.	Per CCS Numbered Letter (NL) 05-1020: CCS & GHPP Policy on Coverage of Experimental and Investigational Services	Aligns the Policy with Classic CCS guidelines for coverage of Investigational Services.
IX	Updated glossary terms, including: Durable Medical Equipment, Medically Necessary or Medical Necessity and Prior Authorization	Ensures all standard glossary terms are consistent across CalOptima Policies.	

2. **Policy GG.1301: Comprehensive Case Management Process** defines the guidelines for Case Management of Members enrolled in the Medi-Cal program, by CalOptima or a Health Network.

Policy Section	Proposed Change	Rationale	Impact
II.C and III.G-H	Language added describing assessment and evaluation for a Member in Complex Case Management, including Social Determinants of Health, functional capacity, and includes analyzing the information for meaning for integration into the Individual Care Plan.	Updates to NCQA Standards, reflecting the increasing focus on Social Determinants of Health and the importance of drawing a conclusion about the impact of various elements at the time of Member assessment.	CalOptima and our Health Networks have received training and education on revisions to NCQA Standards and implemented modifications to medical management systems to support the revised requirements.
II.E	Added language including Whole Child Model Members and references to CalOptima Policy GG.1330 Case Management - California Children's Services Whole-Child Model.	WCM Members may receive Complex Case Management in accordance with this policy. CalOptima Policy GG.1330 Case Management - California Children's Services Whole-Child Model describes how case management is provided to WCM Members.	Aligns the Policy with Whole Child Model requirements.

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Policy Section	Proposed Change	Rationale	Impact
II.F	Included Members enrolled in the Health Homes Program and added reference to CalOptima Policy GG.1331: Health homes Program (HHP) Services and Care Management.	CalOptima implemented the Health Homes Program January 1, 2020.	Aligns the Policy with the Health Homes Program.
II.G, III.E.11	Added language referring to providing Case Management for Members approved for Private Duty Nursing Services and reference to CalOptima Policy GG.1352: Private Duty Nursing Care Management.	New responsibilities were established by DHCS for care coordination of Members receiving Private Duty Nursing	Aligns the Policy with DHCS Private Duty Nursing requirements. CalOptima and Health Network staff have been educated and trained on the new care coordination requirements for PDN.
III.D.8	Added information on how a Member may be referred to or request Case Management Services.	Provided more information to Providers and Members about how to receive Case Management Services.	
III.F.2.b-c	Revised timeframe for completion of the initial Member assessment and Care Plan development to thirty calendar days after the initial referral and the initial assessment, respectively.	Per NCQA 2021 Standards	Allows more time for a Case Manager working with a Member and their Providers, to complete an initial assessment and a Care Plan.

3. **Policy GG.1313: Coordination of Care for Transplant Members** defines the Case Management guidelines for coordination of care by CalOptima and a Health Network for a Medi-Cal member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ Transplant. CalOptima Members who are potential candidates for transplant, except for Kaiser Members, receive case management services directly related to transplant referral and evaluation by CalOptima Case Managers. Case management for all the Member's other services remain the responsibility of the Member's Health Network. When a Member is approved (BMT) or listed (Solid-Organ Transplant), all Case Management services are then provided by CalOptima Case

Managers. Kaiser retains responsibility for Case Management services to its Members, including Case Management services during any phase of the transplant process.

Policy Section	Proposed Change	Rationale	Impact
III.A.2.b	Revised timeframe for urgent authorization processing	Correction to policy	None. Aligns with current operations.
III.A.2.d	Removed limit on time for evaluation by the Transplant Center	No regulatory requirement, is subject to a member's individual medical condition.	Aligns with current operations.
III.B.2.b	Removed outdated language that requires Kaiser to send requests to CalOptima for review of Kaiser's decisions regarding authorization of Transplant services in any phase.	No longer applicable	None. Aligns with current operations.
IX	Update glossary terms, including California Children Services Program (CCS), California Children Services Program (CCS) Eligible Conditions, Covered Services, Designated Special Care Center, Department of Health Care Services, Medically Necessary or Medical Necessity, Member, Urgent Care, Whole Child Model (WCM) Program	Ensure consistency of defined terms across CalOptima policies	

Fiscal Impact

The recommended action to authorize the CEO to revise CalOptima Policies GG.1102, GG.1301 and GG.1313 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy GG. 1102: Experimental and Investigational Service Coverage (Redlined and Clean versions)
2. Policy GG.1301: Comprehensive Case Management Process (Redlined and Clean versions)
3. Policy GG.1313: Coordination of Care for Transplant Members (Redlined and Clean versions)

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Policy:	GG.1102
Title:	**Experimental and Investigational Service Coverage**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	02/01/2002
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administration

I. PURPOSE

This policy defines the benefit coverage for Experimental and Investigational Services under the CalOptima program.

II. POLICY

A. Experimental Services are not covered under the Department of Health Care Services (DHCS) Medi-Cal program, Whole Child Model (WCM) program, or the Centers for Medicare & Medicaid Services (CMS) Medicare or Duals Demonstration programs~~.~~, except as specified in this Policy or specifically authorized by law.

B. Coverage of Investigational Services in the Medi-Cal program

1. Investigational Services require Prior Authorization, and are covered when it is clearly documented that all of the following apply:

   a. The Member has a life threatening or seriously debilitating disease or medical condition;

   b. There is a medically reasonable expectation that the Investigational Service will significantly prolong the intended Member's life or will maintain or restore a range of physical and social function suited to Activities of Daily Living (ADL);

   c. Conventional therapy will not prevent progressive disability or premature death, nor adequately treat the intended Member's condition;

   d. The provider of the proposed service has a record of safety and success, which is equivalent or superior to that of other providers of the Investigational Service; ~~and~~

   e. The Investigational Service is the lowest cost item or service that meets the Member's medical needs and is less costly than all conventional alternatives; and

   ~~e.~~f. The service is not being performed as a part of a research study protocol.

C. Coverage of Investigational Services in the OneCare and OneCare Connect programs

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1. Category A and Category B Investigational Device Exemption (IDE) studies require Prior Authorization, and are covered when the following requirements are met:

   a. The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients;

   b. The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c. The study results are not anticipated to unjustifiably duplicate existing knowledge;

   d. The study design is methodologically appropriate, and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study;

   e. The study is sponsored by an organization or individual capable of successfully completing the study;

   f. The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in Title 21 of the Code of Federal Regulations (CFR), Parts 50, 56, and 812, and Title 45, CFR., Part 46;

   g. Where appropriate, the study is not designed to exclusively test toxicity, or disease pathophysiology, in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one (1) of the objectives may be exempt from this criterion, only if the disease or condition being studied is life threatening and the patient has no other viable treatment options;

   h. The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov;

   i. The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes, and that the release should be hastened if the study is terminated early; and

   j. The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.

D. CalOptima shall cover cancer Clinical Trials, in accordance with CalOptima Policy GG.1125: Cancer Clinical Trials.

E. Coverage for routine costs of qualifying Clinical Trials are covered upon approval by the Chief Medical Officer (CMO~~),~~ ,) or his or her Designee, unless the coverage of the service is otherwise defined as a non-covered service or item in Title 22, California Code of Regulations (C.C.R~~), or Title 42, United States Code (U.S.C.), Section 300gg-8.~~).

F. Coverage for Clinical Trials is restricted to participating hospitals and physicians in California, unless the protocol for the Clinical Trial is not provided for at a California hospital or by a California physician.

G. For the Medi-Cal ~~programs~~program, CalOptima~~,~~ or a Health Network~~,~~ shall provide coverage for routine costs for Investigational Services associated with a Clinical Trial, if the Clinical Trial meets the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within the benefit category of the Medicaid/Medicare program (e.g., Physician's service, Durable Medical Equipment (DME), diagnostic test) and are not ~~be~~ statutorily excluded from coverage (e.g., cosmetic surgery).

2. The trial must not be designed exclusively to test toxicity, or disease pathophysiology. It must have therapeutic intent and be considered a Phase III Clinical Trial in the United States.

3. Trials of therapeutic interventions must enroll patients with a diagnosed disease, rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients, in order to have a proper control group.

H. The requirements in Section II.G. of this ~~policy~~Policy are insufficient by themselves to qualify a Clinical Trial for the Medicare Clinical Trial registry and OneCare and OneCare Connect coverage for routine costs. A Clinical Trial shall have the following ~~desirable~~ characteristics:

1. The principal purpose of the Clinical Trial is to test whether the intervention potentially improves the Member's health outcomes;

2. The Clinical Trial is well-supported by available scientific and medical information, or is intended to clarify, or establish, the health outcomes of interventions already in common clinical use;

3. The Clinical Trial does not unjustifiably duplicate existing studies;

4. The Clinical Trial design is appropriate to answer the research question being asked in the Clinical Trial;

5. The Clinical Trial is sponsored by a credible organization or individual capable of executing the proposed Clinical Trial successfully;

6. The Clinical Trial is in compliance with Federal regulations relating to the protection of human subjects; and

7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.

~~Routine costs in Clinical Trials include:~~

~~1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);~~

~~2.~~1. ~~Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);~~

~~3.~~1. ~~The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and~~

~~4.~~1. ~~Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.~~

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~~D. Routine costs exclude the following:~~

~~1. The Investigational Service or item;~~

~~2.~~1. ~~Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);~~

~~3.~~1. ~~Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and~~

~~4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.~~

I. Payment will not be authorized for Investigational Services that do not meet the ~~above~~ criteria set out in this Policy, or for associated inpatient care, when a Member needs to be in the hospital primarily because she or he is receiving such non-approved Investigational Services. For non-covered items and services, only the treatment of complications arising from the delivery of the non-covered item or service, and unrelated reasonable and necessary care is a covered benefit.

III. PROCEDURE

A. All requests for Investigational Services or Experimental Services, including Clinical Trials, must be reviewed and authorized by the CMO~~,~~ or his or her Designee~~,~~ prior to services being provided to Members.

1. For WCM Members, requests shall be evaluated for Medical Necessity in accordance with California Children's Services (CCS) guidelines as provided in CCS Numbered Letters.

2. In addition, for WCM Members, CalOptima shall authorize Investigational Services or Experimental Services in accordance with GG.1508: Authorization and Processing of Referrals or CCS Numbered Letters, whichever is least restrictive and as applicable.

B. Determination that a service is Experimental or Investigational is based on:

1. Relevant Federal regulations or guidance, such as those contained in Title 42, CFR, Chapter IV, and Title 21, CFR, Chapter I, Food and Drug Administration (FDA) 510k approvals, and certain other categories of FDA approval for limited use or continuing research, do not represent full and unrestricted FDA acceptance and would still be considered investigational. Further, devices or therapies which are fully FDA approved for some indications but are being used for indications other than those for which there is an FDA approval may also be deemed investigational;

2. Verification that the Clinical Trial meets the criteria for being registered with the Medicare clinical trials registry;

3. Consultation with provider organizations, academic and professional specialists pertinent to the specific medical service; and

4. Current medical literature in the United States.

C. Routine costs in Clinical Trials include:

1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);

2. Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);

3. The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

4. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

D. Routine costs exclude the following:

1. The Investigational Service or item;

2. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.

E. A Member may appeal a CalOptima or Health Network decision to a requested service in accordance with CalOptima policies GG.1510: Appeal Process, MA.9003: Standard Appeal, and CMC.9003: Standard Appeal.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy MA.9003: Standard Appeal
~~E.~~F. CalOptima Policy CMC.9003: Standard Appeal
~~F.~~G. CalOptima Policy GG.1125: Cancer Clinical Trials
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~G.~~I. CalOptima Policy GG.1510: Appeal Process ~~CalOptima Policy MA.9003: Standard Appeal~~
~~H.~~J. Centers for Medicare & Medicaid Services, National Coverage Determination for Routine Costs in Clinical Trials, July 9, 2007
K. DHCS CCS Numbered Letter (N.L.) 05-1020: California Children's Services Program and Genetically Handicapped Persons Program Policy on Coverage of Experimental and Investigational Services

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~~I.~~L. Final National Coverage Decision-Clinical Trials, Social Security Act, Section 1862 (a)(1)(E)
~~J.~~M. Medicare Managed Care Manual, Chapter 4, Section 10.7.2
~~K.~~N. Medicare Benefit Policy Manual, Chapter 14, Section 20
~~L.~~O. Medicare Approved Clinical Trials/Clinical Research Studies List
~~M.~~P. Title 21, Code of Federal Regulations, Chapter I
~~N.~~Q. Title 22, California Code of Regulations, §§51056.1, 51303 (g) and (h)
~~O.~~R. Title 42, Code of Federal Regulations, Chapter IV
~~P.~~S. Title 42, United States Code, §300gg-8
~~Q.~~T. Welfare and Institutions Code, §14132.98

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2002	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal
Revised	05/01/2007	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal
Reviewed	09/01/2014	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal
Effective	08/01/2005	MA.6008	Experimental and Investigational Service	OneCare
Revised	07/01/2008	MA.6008	Experimental and Investigational Service	OneCare
Revised	11/01/2015	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6008	Experimental and Investigational Service	OneCare
Revised	10/01/2016	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	12/01/2018	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	06/01/2020	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Category A Experimental Device	A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective.
Category B Non-Experimental/Investigational Device	A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration FDA premarket approval or clearance for that device type.
Clinical Trials	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME:~~Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient that:~~ 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.

Term	Definition
Experimental Services	Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans.
Investigational Services	Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in progress but testing is not complete (Phase III clinical trials are not yet completed and published), the efficacy and safety of such services in human subjects are not yet established, and the service is not generally accepted by the medical community in the United States or in widespread general medical usage in the United States.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	~~An Member~~ A beneficiary ~~of~~enrolled in a CalOptima program.

Term	Definition
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval ~~to provide specific services or procedures~~of Medically Necessary Covered Services, including the ~~Medically Necessary and to what~~ amount, duration, and scope of services, except in the case of an emergency. OneCare &~~/~~ OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member.

Policy:	GG.1102
Title:	**Experimental and Investigational Service Coverage**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	02/01/2002
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administration

I. PURPOSE

This policy defines the benefit coverage for Experimental and Investigational Services under the CalOptima program.

II. POLICY

A. Experimental Services are not covered under the Department of Health Care Services (DHCS) Medi-Cal program, Whole Child Model (WCM) program, or the Centers for Medicare & Medicaid Services (CMS) Medicare or Duals Demonstration programs, except as specified in this Policy or specifically authorized by law.

B. Coverage of Investigational Services in the Medi-Cal program

1. Investigational Services require Prior Authorization, and are covered when it is clearly documented that all of the following apply:

   a. The Member has a life threatening or seriously debilitating disease or medical condition;

   b. There is a medically reasonable expectation that the Investigational Service will significantly prolong the intended Member's life or will maintain or restore a range of physical and social function suited to Activities of Daily Living (ADL);

   c. Conventional therapy will not prevent progressive disability or premature death, nor adequately treat the intended Member's condition;

   d. The provider of the proposed service has a record of safety and success, which is equivalent or superior to that of other providers of the Investigational Service;

   e. The Investigational Service is the lowest cost item or service that meets the Member's medical needs and is less costly than all conventional alternatives; and

   f. The service is not being performed as a part of a research study protocol.

C. Coverage of Investigational Services in the OneCare and OneCare Connect programs

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1. Category A and Category B Investigational Device Exemption (IDE) studies require Prior Authorization, and are covered when the following requirements are met:

    a. The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients;

    b. The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

    c. The study results are not anticipated to unjustifiably duplicate existing knowledge;

    d. The study design is methodologically appropriate, and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study;

    e. The study is sponsored by an organization or individual capable of successfully completing the study;

    f. The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in Title 21 of the Code of Federal Regulations (CFR), Parts 50, 56, and 812, and Title 45, CFR., Part 46;

    g. Where appropriate, the study is not designed to exclusively test toxicity, or disease pathophysiology, in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one (1) of the objectives may be exempt from this criterion, only if the disease or condition being studied is life threatening and the patient has no other viable treatment options;

    h. The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov;

    i. The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes, and that the release should be hastened if the study is terminated early; and

    j. The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.

D. CalOptima shall cover cancer Clinical Trials, in accordance with CalOptima Policy GG.1125: Cancer Clinical Trials.

E. Coverage for routine costs of qualifying Clinical Trials are covered upon approval by the Chief Medical Officer (CMO) or his or her Designee, unless the coverage of the service is otherwise defined as a non-covered service or item in Title 22, California Code of Regulations (C.C.R).

F. Coverage for Clinical Trials is restricted to participating hospitals and physicians in California, unless the protocol for the Clinical Trial is not provided for at a California hospital or by a California physician.

G. For the Medi-Cal program, CalOptima or a Health Network shall provide coverage for routine costs for Investigational Services associated with a Clinical Trial, if the Clinical Trial meets the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within the benefit category of the Medicaid/Medicare program (e.g., Physician's service, Durable Medical Equipment (DME), diagnostic test) and are not statutorily excluded from coverage (e.g., cosmetic surgery).

2. The trial must not be designed exclusively to test toxicity, or disease pathophysiology. It must have therapeutic intent and be considered a Phase III Clinical Trial in the United States.

3. Trials of therapeutic interventions must enroll patients with a diagnosed disease, rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients, in order to have a proper control group.

H. The requirements in Section II.G. of this Policy are insufficient by themselves to qualify a Clinical Trial for the Medicare Clinical Trial registry and OneCare and OneCare Connect coverage for routine costs. A Clinical Trial shall have the following characteristics:

1. The principal purpose of the Clinical Trial is to test whether the intervention potentially improves the Member's health outcomes;

2. The Clinical Trial is well-supported by available scientific and medical information, or is intended to clarify, or establish, the health outcomes of interventions already in common clinical use;

3. The Clinical Trial does not unjustifiably duplicate existing studies;

4. The Clinical Trial design is appropriate to answer the research question being asked in the Clinical Trial;

5. The Clinical Trial is sponsored by a credible organization or individual capable of executing the proposed Clinical Trial successfully;

6. The Clinical Trial is in compliance with Federal regulations relating to the protection of human subjects; and

7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.

I. Payment will not be authorized for Investigational Services that do not meet the criteria set out in this Policy, or for associated inpatient care, when a Member needs to be in the hospital primarily because she or he is receiving such non-approved Investigational Services. For non-covered items and services, only the treatment of complications arising from the delivery of the non-covered item or service, and unrelated reasonable and necessary care is a covered benefit.

III. PROCEDURE

A. All requests for Investigational Services or Experimental Services, including Clinical Trials, must be reviewed and authorized by the CMO or his or her Designee prior to services being provided to Members.

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1. For WCM Members, requests shall be evaluated for Medical Necessity in accordance with California Children's Services (CCS) guidelines as provided in CCS Numbered Letters.

2. In addition, for WCM Members, CalOptima shall authorize Investigational Services or Experimental Services in accordance with GG.1508: Authorization and Processing of Referrals or CCS Numbered Letters, whichever is least restrictive and as applicable.

B. Determination that a service is Experimental or Investigational is based on:

1. Relevant Federal regulations or guidance, such as those contained in Title 42, CFR, Chapter IV, and Title 21, CFR, Chapter I, Food and Drug Administration (FDA) 510k approvals, and certain other categories of FDA approval for limited use or continuing research, do not represent full and unrestricted FDA acceptance and would still be considered investigational. Further, devices or therapies which are fully FDA approved for some indications but are being used for indications other than those for which there is an FDA approval may also be deemed investigational;

2. Verification that the Clinical Trial meets the criteria for being registered with the Medicare clinical trials registry;

3. Consultation with provider organizations, academic and professional specialists pertinent to the specific medical service; and

4. Current medical literature in the United States.

C. Routine costs in Clinical Trials include:

1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);

2. Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);

3. The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

4. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

D. Routine costs exclude the following:

1. The Investigational Service or item;

2. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.

E. A Member may appeal a CalOptima or Health Network decision to a requested service in accordance with CalOptima policies GG.1510: Appeal Process, MA.9003: Standard Appeal, and CMC.9003: Standard Appeal.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy MA.9003: Standard Appeal
F. CalOptima Policy CMC.9003: Standard Appeal
G. CalOptima Policy GG.1125: Cancer Clinical Trials
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process
J. Centers for Medicare & Medicaid Services, National Coverage Determination for Routine Costs in Clinical Trials, July 9, 2007
K. DHCS CCS Numbered Letter (N.L.) 05-1020: California Children's Services Program and Genetically Handicapped Persons Program Policy on Coverage of Experimental and Investigational Services
L. Final National Coverage Decision-Clinical Trials, Social Security Act, Section 1862 (a)(1)(E)
M. Medicare Managed Care Manual, Chapter 4, Section 10.7.2
N. Medicare Benefit Policy Manual, Chapter 14, Section 20
O. Medicare Approved Clinical Trials/Clinical Research Studies List
P. Title 21, Code of Federal Regulations, Chapter I
Q. Title 22, California Code of Regulations, §§51056.1, 51303 (g) and (h)
R. Title 42, Code of Federal Regulations, Chapter IV
S. Title 42, United States Code, §300gg-8
T. Welfare and Institutions Code, §14132.98

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2002	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal
Revised	05/01/2007	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal
Reviewed	09/01/2014	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.6008	Experimental and Investigational Service	OneCare
Revised	07/01/2008	MA.6008	Experimental and Investigational Service	OneCare
Revised	11/01/2015	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6008	Experimental and Investigational Service	OneCare
Revised	10/01/2016	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	12/01/2018	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	06/01/2020	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1102	Experimental and Investigational Service Coverage	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Category A Experimental Device	A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective.
Category B Non-Experimental/Investigational Device	A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration FDA premarket approval or clearance for that device type.
Clinical Trials	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Experimental Services	Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans.

Term	Definition
Investigational Services	Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in progress but testing is not complete (Phase III clinical trials are not yet completed and published), the efficacy and safety of such services in human subjects are not yet established, and the service is not generally accepted by the medical community in the United States or in widespread general medical usage in the United States.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary enrolled in a CalOptima program.

Term	Definition
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration, and scope of services, except in the case of an emergency. OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member.

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Policy:	GG.1301
Title:	**Comprehensive Case Management Process**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal program, by CalOptima~~,~~ or a Health Network.

II. POLICY

A. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

B. The goal of Complex Case Management is to help a Member regain optimum health~~,~~ or improve functional capability, in the least restrictive setting and in a cost-effective manner.

1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.

~~C.~~ Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition, functional capacity, determination of available benefits ~~and~~, resources, cultural and ~~development~~linguistic needs, Social Determinants of Health, and ~~implementation of a Case Management plan with performance goals, monitoring,~~barriers to care. This information is analyzed for meaning and ~~follow up.~~

~~D. The Complex Case Management program description shall include the following:~~

~~1.~~ ~~Evidence used~~evaluated in a member-centric manner in order to develop ~~the program, including but not limited to:~~

~~a. Milliman~~and implement an Individual Care ~~Guidelines (MCG);~~

~~b. Institute for Clinical Improvement (ICSI);~~

~~c. Department of Health Care Services (DHCS) guidelines;~~

~~d. Centers for Medicare & Medicaid Services (CMS) guidelines;~~

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e. Local and Intermediary Medicare Carrier coverage guidelines;

f. Centers of Excellence guidelines; and

g. Preventive health guidelines (e.g., U.S. Preventive Services Task Force).

2. Criteria used to identify Members who are eligible for the program;

3. Services offered to Members;

4. Defined programPlan (ICP) with prioritized Member goals;

E.C. Case management services that are combined with the services of others involved in a Member's care.followed up on and monitored for progress.

F. Annually, CalOptima shall assess the characteristics and needs of its Member population and relevant subpopulations, which include, but are not limited to:

1. Children, adolescents, persons with disabilities, and persons with serious and persistent mental illness (SPMI): To assess the characteristics and needs of these subpopulations, CalOptima may use the following:

a. Race;

b. Ethnicity;

c. Language preference;

d. Member gender;

e. Member age;

f. Aid code category;

g. Severe diagnoses;

h. Co-morbid diagnoses;

i. Behavioral health diagnosis;

j. Inpatient admissions;

k. Emergency department utilization; and

l. Number of prescriptions.

G. The following data sources shall be utilized for the population assessment:

a. Information from the Department of Health Care Services (DHCS) (e.g., eligibility files);

b. Claims data; and

c. Encounter data;

~~H.~~D. CalOptima shall review and update its Case Management processes and resources to address Member needs, if necessary.

E. CalOptima or a Health Network shall ensure the provision of Case Management for CalOptima Members eligible with the California Children's Services (CCS) Program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

F. CalOptima or a Health Network shall ensure the provision of care management and care coordination for Members enrolled in the Health Homes Program in accordance with CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

G. CalOptima or a Health Network shall ensure the provision of Case Management services for Members approved for Private Duty Nursing Services in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management.

III. PROCEDURE

A. CalOptima and a Health Network shall identify Members for Complex Case Management utilizing the following data sources~~:~~:

1. Claims~~,~~ or ~~Encounter~~encounter data;
2. Hospital~~,~~ or discharge data;
3. Pharmacy data;
4. Health information form;
5. Data collected through the utilization management (UM) process;
6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;
7. Data supplied by Member~~,~~ or caregiver; and
8. Data supplied by Practitioners.

B. CalOptima~~,~~ or a Health Network~~,~~ shall assess and provide Complex Case Management, as appropriate, to the following Members:

1. A Member who is high-risk, defined as:

a. A Member who has a medically~~-~~ complex condition, including the most frequently managed conditions~~, diseases,~~; or ~~high~~

~~a.~~b. High risk groups, that may include, but ~~is~~are not limited to~~:~~:

i. Spinal Injuries;

ii. Transplants;

iii. Cancer;

iv. Serious Trauma;

v. AIDS;

vi. Multiple chronic illnesses; and

vii. Chronic illnesses that result in high utilization.

2. A Member who has a complex social situation that affects the medical management of the Member's care;

3. A Member who requires an extensive use of resources; or

4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

C. CalOptima~~,~~ or a Health Network~~,~~ may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management~~,~~ but would benefit from case management support. Care Coordination Case Management shall include:

1. Assistance with access to care issues;

2. Health and disease-specific education;

3. Referral to resources; and

4. Coordination of care with all Providers.

D. A Member may be referred to Complex Case Management through:

1. ~~Disease~~ Medical Management program referral;

2. Discharge ~~Planner~~planner referral;

3. ~~Utilization Management (~~UM~~)~~ referral~~, if applicable;~~;

4. Member or caregiver referral;

5. Practitioner referral;

6. Community agency; and

7. Health Network referral.

8. CalOptima shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:

a. Member ~~,~~newsletter;

b. Provider communications, including but not limited to, the Provider newsletter; and

c. Other materials or forums, as appropriate.

~~8.~~9. CalOptima or a Health Network~~,~~ may receive referrals by electronic transmission, telephone, or written correspondence.

E. The Complex Case Management ~~program~~process shall include, but not be limited to:

1. Standardized mechanisms to systematically identify a high-risk Member;

2. Access to Case Management by ensuring multiple avenues for referrals;

3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case Management programs and services offered by CalOptima~~,~~ or a Health Network;

4. Complex Case Management system;

5. Documented Case Management process;

6. Initial assessment;

7. Process for providing ongoing Case Management;

8. Coordination of care to ensure provision of all Medically Necessary services;

9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary services;

10. Coordination of carve-out services;

11. Coordination of PDN nursing in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management, if applicable;

~~11.~~12. Coordination of services, both within and outside CalOptima's Service Area;

~~12.~~13. Coordination of long term services and supports (LTSS);

~~13.~~14. Coordination of behavioral health services;

~~14.~~15. Process for evaluating satisfaction with the Case Management program;

~~15.~~16. Process for measuring the effectiveness of Case Management; and

~~16.~~17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

~~I. CalOptima and a Health Network shall utilize Case Management systems that support Complex Case Management, as follows:~~

~~1. Evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;~~

2. A documentation process that includes automated notation of the staff members identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up contact scheduled with the Member.

I. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2.1. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. How CalOptima, or the Health Network, works with a Member in the Case Management program.

J.I. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's, or Health Network's, Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2.1. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

J. Annually, CalOptima shall analyze the effectiveness of its Complex Case Management program by identifying three (3) measures. For each identified measure, CalOptima shall:

1. Identify a relevant process or outcome;

2. Use a valid method that provides quantitative results;

3. Set a performance measure;

4. Clearly identify measure specifications;

5. Collect data and analyze results; and

6. Identify opportunities for improvement, if applicable.

K. Based on the measurement and analysis of Complex Case Management program effectiveness outcomes, CalOptima shall:

1. Implement at least one (1) intervention to improve performance, if applicable

2. Implement at least one (1) intervention to improve satisfaction, if applicable;

3. Re-measure to determine impact performance, if applicable; and

4. Re-measure to determine impact on satisfaction, if applicable.

~~L. CalOptima shall monitor a Health Network's Case Management program, in accordance with this policy and CalOptima Policy GG.1619: Delegation Oversight.~~

~~M. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) Targeted Case Management (TCM) services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:~~

~~Children under age twenty-one (21).~~

~~b. Medically fragile individuals.~~

~~c.~~b. ~~Individuals at risk of institutionalization.~~

~~d.~~b. ~~Individuals in jeopardy of negative medical, or psycho-social, outcomes.~~

~~e.~~b. ~~Individuals with a communicable disease.~~

~~N. CalOptima and a Health Network may identify and refer a member for DHCS TCM services when the Member meets the appropriate criteria listed below:~~

~~a. Member is determined to be in need of case management services for non-medical needs.~~

~~b.~~a. ~~CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.~~

~~c.~~a. ~~CalOptima has determined that Member would benefit from TCM face-to-face case management.~~

~~d.~~a. ~~CalOptima has concerns that the Member has an inadequate support system for medical care.~~

~~e.~~a. ~~CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.~~

~~O. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima, or a Health Network.~~

~~P. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima, or a Health Network.~~

~~Q. For Members who have both a TCM case manager and a CalOptima, or Health Network, case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.~~

~~III.~~I. ~~PROCEDURE~~

F. Triage Process

1. Upon receipt of a referral for Case Management, CalOptima~~,~~ or a Health Network~~,~~ shall triage the referral for Case Management as follows:

a. CalOptima~~,~~ or a Health Network~~,~~ shall triage an urgent referral within ~~twenty-four (24) hours~~one (1) business day after receipt of the referral.

b. CalOptima~~,~~ or a Health Network~~,~~ shall triage a standard referral within five (5) business days after receipt of the referral.

2. If, upon review of a referral for Care Coordination Case Management~~,~~ or Complex Case Management, CalOptima~~,~~ or a Health Network~~,~~ determines that a Member qualifies for Care Coordination Case Management~~,~~ or Complex Case Management, CalOptima~~,~~ or a Health Network~~,~~ shall:

a. Contact the Member to obtain consent for Care Coordination Case Management~~,~~ or Complex Case Management~~,~~ services within ~~twenty-four (24) hours~~one (1) business day for an urgent referral and within five (5) business days for a routine referral;

b. ~~Perform~~Complete an initial assessment for the Member~~-~~ within ~~five (5) business~~thirty (30) calendar days ~~after the Member consents to Care Coordination Case Management, or Complex Case Management services;~~ of identification; and

c. Develop an ~~Individual Care Plan (~~ICP~~)~~ within ~~ten (10) business~~thirty (30) calendar days ~~after the completion of the initial~~of assessment.

G. Initial Member Assessment

1. CalOptima~~,~~ or a Health Network~~,~~ shall conduct a Member's initial assessment and evaluation in the following manner:

a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family~~,~~ or caregiver;

b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

c. Review of Medical Records by a case manager, as needed;

d. Consultation with CalOptima's or Health Networks' staff, as needed; or

e. Consultation with a community agency, as needed.

2. CalOptima~~,~~ or a Health Network~~,~~ shall include the following in a Member's initial assessment and evaluation for Complex Case Management~~:~~. CalOptima or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (*e.g.*, life-planning in pediatric cases).

a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status~~, and information~~. Information on the event or diagnosis that led to the Member's eligibility for Case Management~~.~~, and current medications, including schedules and dosages.

b. Documentation of clinical history~~,~~ including:

i. Dates;

ii. Disease ~~disease~~ onset~~, comorbidities, and key events, such as acute phases, inpatient stays,~~ ;

iii. Past hospitalizations and major procedures, including surgery;

~~i.~~iv. Significant past illnesses and treatment history~~, and current and past medications, including schedules and dosages;~~; and

~~b. Capacity for carrying out activities of daily living (ADLs), such as eating, bathing, and mobility, and instrumental activities of daily living (IADLs), such as light housekeeping, shopping and laundry;~~

v. Relevant past medications related to the Member's condition.

vi. This factor does not require evaluation.

c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., "Member is fully independent with ADLs.").

~~c.~~d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions~~,~~ or substance use disorders~~;~~.

~~d.~~e. ~~Identification~~Assessment of ~~possible psychosocial issues~~Social Determinants of Health that may affect Members' ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment~~;~~ (as Social Determinants of Health are a combination of influences, assessment must include more than one (1) Social Determinant of Health).

~~e.~~f. Assessment of the Member's life planning activities, such as wills, living wills, or advance directives ~~and~~, health care powers of attorney~~.~~, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima~~,~~ or a Health Network~~,~~ shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities~~;~~.

~~f.~~g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs~~;~~.

~~g.~~h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member~~;~~.

~~h.~~i. ~~Caregiver~~Evaluation for adequacy of caregiver resources, such as family or other support person involvement ~~in~~ and role in decision making about the care plan ~~and address~~

adequacy of . Documentation describes the resources; in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.

i.j. Evaluation of available benefits, including the Member's eligibility and pertinent financial information regarding benefits. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:

i. Benefits covered by the CalOptima, the Health NetworksNetwork, and by Providers (i.e., Disease Management and Health Education);;

ii. Services carved-out by CalOptima and Health Networks; and

iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).

k. Evaluation of community resources, including assessments of potential eligibility for community resources that supplement CalOptima resources, such as community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan.

j.l. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

i. California Children's Services (CCS), as described in CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program;

ii. Genetically Handicapped Persons Program (GHPP);

iii. HIV/AIDS Waiver Program;

iv. Home and Community-Based Services (HCBS);

v. Local Educational Agency (LEA);

vi. Regional Center of Orange County (RCOC);) ;

vii. In-Home Operations;

viii. Specialty Mental Health Services, as described in CalOptima Policy GG.1103: Specialty Mental Health Services;

ix. OCHCA Tuberculosis Program (Direct Observation Therapy); and

x. Long Term Services and Supports, including:

a) Community-Based Adult Services (CBAS);

b) In-Home Support Services (IHSS); and

c) Multipurpose Senior Services Program (MSSP);).

~~3. Evaluation of community resources includes assessments of potential eligibility for providers of benefits supplementing those for which CalOptima has been contracted, such as employee assistance programs (EAP), palliative care programs, wellness organizations, and other national and community resources.~~

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima and a Health Network shall include the following elements in a Member's ICP:

   a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, ~~and includes~~including the following:

      i. Timeframe for re-evaluation;

      ii. Resources to be utilized, including the appropriate level of care;

      iii. Planning for continuity of care, including transition of care and transfers between settings;

      iv. Collaborative approaches to be used, including family participation; and

      v. Evaluating Member's personal preferences.

   b. Identification of barriers to meeting goals, or compliance with ICP:

      i. Barrier analysis shall include issues such as language, or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation, financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.

      ~~ii.~~ Documentation of assessment for barriers, even if none identified.

   c. Coordination of carved out services and referrals to appropriate community resources and agencies.

   d. Facilitation of Member referrals to appropriate resources, and a follow-up process to determine whether Members act on referrals, including referrals to external resources.

   e. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a ~~Disease~~Medical Management program, follow-up after referral to a health resource, and education self-management support.

      i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.

ii. Documentation of the next scheduled Member contact and contact method.

f. Development and communication (e.g., orally or written) of a ~~Member's~~ self-management plan ~~of activities~~that is acknowledged and agreed to by the Member~~.~~ Self-management plans are ~~designed to shift the focus in patient care from~~actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members ~~receiving care from a Practitioner, or a care team, to Members providing care for themselves, where appropriate.~~or their caregivers. Member self-management plan of activities includes, but is not limited to:

i. Maintaining a prescribed diet;

ii. Charting daily readings (e.g., weight, blood sugar); or

iii. Changing a wound dressing, as directed.

g. ~~A process to assess~~Assessment of progress towards meeting Case Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed.

h. Planning for continuity~~,~~ or transition~~,~~ of care when benefit coverage ends. CalOptima~~,~~ or a Health Network~~,~~ shall:

i. Identify transitioning Members who are receiving approved services, but whose benefit coverage will end while still needing Medically Necessary care;

ii. Identify available community resources and alternative care; and

iii. Notify and educate transitioning Members regarding alternative care and community resources.

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.

4. CalOptima~~,~~ or a Health Network~~,~~ shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.

5. CalOptima and a Health Network shall terminate Complex Case Management for a Member when the Member:

a. Achieves ICP goals;

b. Becomes ineligible for Case Management; or

c. Declines Case Management.

I. Targeted Case Management (TCM)

1. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:

a. Children under age twenty-one (21).

b. Medically fragile individuals.

c. Individuals at risk of institutionalization.

d. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

e. Individuals with a communicable disease.

2. CalOptima and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:

a. Member is determined to be in need of case management services for non-medical needs.

b. CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.

c. CalOptima has determined that Member would benefit from TCM face-to-face case management.

d. CalOptima has concerns that the Member has an inadequate support system for medical care.

e. CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.

3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima or a Health Network.

4. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima or a Health Network.

5. For Members who have both a TCM case manager and a CalOptima or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.

J. CalOptima and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

1. MCG evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;

2. A documentation process that includes automated notation of the staff members' identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

K. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. Information regarding how CalOptima or the Health Network works with a Member in the Case Management program.

L. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's~~,~~ or the Health Network's~~,~~ Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

~~K.~~M. CalOptima shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

~~A. American Accreditation HealthCare Commission/URAC: Case Management Standards~~
~~B.~~A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
~~C.~~B. CalOptima Contract for Health Care Services
~~A.~~ Coordination and Provision of Public Health Care Services Contract~~CalOptima Policy AA.1000: Glossary of Terms~~
C.
D. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
E. CalOptima Policy GG.1103: Specialty Mental Health Services
F. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
G. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
H. CalOptima Policy GG.1352: Private Duty Nursing Care Management
~~F.~~I. CalOptima Policy GG.1619: Delegation Oversight
~~G.~~J. Case Management Society of America (CMSA): Standards of Practice for Case Management
~~B. Coordination and Provision of Public Health Care Services Contract, Amendment I~~
~~H.~~K. National Committee for Quality Assurance (NCQA) ~~2017 QI~~2021 PHM 5: Complex Case Management
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children's Service Whole Child Model Program
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
~~I.~~O. Title 22, California Code of Regulations (C.C.R.), §~~-~~51185
~~C. Welfare and Institutions Code, § 14132.44~~

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
09/09/2015	Department of Health Care Services (DHCS)
01/20/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2010	GG.1301	Case Management Process	Medi-Cal
Revised	08/01/2011	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2013	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2014	GG.1301	Complex Case Management Process	Medi-Cal
Revised	04/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	11/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	10/01/2016	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	07/01/2017	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	TBD	GG.1301	Comprehensive Case Management Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
~~CalOptima~~California Children's Services (CCS)	~~For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).~~The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Complex Case Management	~~A program~~The systematic coordination and assessment of ~~coordinated~~ care and services ~~for members~~provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Complex Case Management Eligible Member	Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to: 1. Spinal Injuries; 2. Transplants; 3. Cancer; 4. Serious trauma; 5. AIDS; 6. Multiple chronic illnesses; or 7. Chronic illnesses that result in high utilization. Or Member with a ~~Medical Condition~~medical condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

Term	Definition
Medical Management Program	Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. ~~Reasonable and necessary services~~Covered Services ~~to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. , achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members receiving MLTSS, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services.~~ ~~When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).~~
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.

Term	Definition
Private Duty Nursing (PDN)	Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse.
Service Area	The ~~geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a~~ county or counties that CalOptima is approved to operate in under the terms of the DHCS contract.
Social Determinants of Health	Economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.
Targeted Case Management	~~Specialized case management services for~~Services which assist Medi-Cal ~~eligible individuals in a defined~~Members within specified target ~~population~~groups to gain access to needed medical, social, educational~~,~~ and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1

Policy:	GG.1301
Title:	**Comprehensive Case Management Process**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal program, by CalOptima or a Health Network.

II. POLICY

A. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

B. The goal of Complex Case Management is to help a Member regain optimum health or improve functional capability, in the least restrictive setting and in a cost-effective manner.

1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.

C. Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition, functional capacity, determination of available benefits, resources, cultural and linguistic needs, Social Determinants of Health, and barriers to care. This information is analyzed for meaning and evaluated in a member-centric manner in order to develop and implement an Individual Care Plan (ICP) with prioritized Member goals that are followed up on and monitored for progress.

D. CalOptima shall review and update its Case Management processes and resources to address Member needs, if necessary.

E. CalOptima or a Health Network shall ensure the provision of Case Management for CalOptima Members eligible with the California Children's Services (CCS) Program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

F. CalOptima or a Health Network shall ensure the provision of care management and care coordination for Members enrolled in the Health Homes Program in accordance with CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

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G. CalOptima or a Health Network shall ensure the provision of Case Management services for Members approved for Private Duty Nursing Services in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management.

III. PROCEDURE

A. CalOptima and a Health Network shall identify Members for Complex Case Management utilizing the following data sources:

1. Claims or encounter data;
2. Hospital or discharge data;
3. Pharmacy data;
4. Health information form;
5. Data collected through the utilization management (UM) process;
6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;
7. Data supplied by Member or caregiver; and
8. Data supplied by Practitioners.

B. CalOptima or a Health Network shall assess and provide Complex Case Management, as appropriate, to the following Members:

1. A Member who is high-risk, defined as:
    a. A Member who has a medically complex condition, including the most frequently managed conditions; or
    b. High risk groups, that may include, but are not limited to:
        i. Spinal Injuries;
        ii. Transplants;
        iii. Cancer;
        iv. Serious Trauma;
        v. AIDS;
        vi. Multiple chronic illnesses; and
        vii. Chronic illnesses that result in high utilization.
2. A Member who has a complex social situation that affects the medical management of the Member's care;
3. A Member who requires an extensive use of resources; or

4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

C. CalOptima or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:

1. Assistance with access to care issues;

2. Health and disease-specific education;

3. Referral to resources; and

4. Coordination of care with all Providers.

D. A Member may be referred to Complex Case Management through:

1. Medical Management program referral;

2. Discharge planner referral;

3. UM referral;

4. Member or caregiver referral;

5. Practitioner referral;

6. Community agency; and

7. Health Network referral.

8. CalOptima shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:

a. Member newsletter;

b. Provider communications, including but not limited to, the Provider newsletter; and

c. Other materials or forums, as appropriate.

9. CalOptima or a Health Network may receive referrals by electronic transmission, telephone, or written correspondence.

E. The Complex Case Management process shall include, but not be limited to:

1. Standardized mechanisms to systematically identify a high-risk Member;

2. Access to Case Management by ensuring multiple avenues for referrals;

3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case Management programs and services offered by CalOptima or a Health Network;

4. Complex Case Management system;

5. Documented Case Management process;

6. Initial assessment;

7. Process for providing ongoing Case Management;

8. Coordination of care to ensure provision of all Medically Necessary services;

9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary services;

10. Coordination of carve-out services;

11. Coordination of PDN nursing in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management, if applicable;

12. Coordination of services, both within and outside CalOptima's Service Area;

13. Coordination of long term services and supports (LTSS);

14. Coordination of behavioral health services;

15. Process for evaluating satisfaction with the Case Management program;

16. Process for measuring the effectiveness of Case Management; and

17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

F. Triage Process

1. Upon receipt of a referral for Case Management, CalOptima or a Health Network shall triage the referral for Case Management as follows:

   a. CalOptima or a Health Network shall triage an urgent referral within one (1) business day after receipt of the referral.

   b. CalOptima or a Health Network shall triage a standard referral within five (5) business days after receipt of the referral.

2. If, upon review of a referral for Care Coordination Case Management or Complex Case Management, CalOptima or a Health Network determines that a Member qualifies for Care Coordination Case Management or Complex Case Management, CalOptima or a Health Network shall:

   a. Contact the Member to obtain consent for Care Coordination Case Management or Complex Case Management services within one (1) business day for an urgent referral and within five (5) business days for a routine referral;

   b. Complete an initial assessment for the Member within thirty (30) calendar days of identification; and

c. Develop an ICP within thirty (30) calendar days of assessment.

G. Initial Member Assessment

1. CalOptima or a Health Network shall conduct a Member's initial assessment and evaluation in the following manner:

   a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family or caregiver;

   b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

   c. Review of Medical Records by a case manager, as needed;

   d. Consultation with CalOptima's or Health Networks' staff, as needed; or

   e. Consultation with a community agency, as needed.

2. CalOptima or a Health Network shall include the following in a Member's initial assessment and evaluation for Complex Case Management. CalOptima or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (*e.g.,* life-planning in pediatric cases).

   a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status. Information on the event or diagnosis that led to the Member's eligibility for Case Management, and current medications, including schedules and dosages.

   b. Documentation of clinical history including:

      i. Dates;

      ii. Disease onset;

      iii. Past hospitalizations and major procedures, including surgery;

      iv. Significant past illnesses and treatment history; and

      v. Relevant past medications related to the Member's condition.

      vi. This factor does not require evaluation.

   c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., "Member is fully independent with ADLs.").

   d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions or substance use disorders.

e. Assessment of Social Determinants of Health that may affect Members' ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment (as Social Determinants of Health are a combination of influences, assessment must include more than one (1) Social Determinant of Health).

f. Assessment of the Member's life planning activities, such as wills, living wills, or advance directives, health care powers of attorney, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima or a Health Network shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities.

g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member.

i. Evaluation for adequacy of caregiver resources, such as family or other support person involvement-and role in decision making about the care plan. Documentation describes the resources in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.

j. Evaluation of available benefits, including the Member's eligibility and pertinent financial information regarding benefits. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:

    i. Benefits covered by CalOptima, the Health Network, and by Providers;

    ii. Services carved-out by CalOptima and Health Networks; and

    iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).

k. Evaluation of community resources, including assessments of potential eligibility for community resources that supplement CalOptima resources, such as community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan.

l. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

    i. California Children's Services (CCS), as described in CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program;

ii. Genetically Handicapped Persons Program (GHPP);

iii. HIV/AIDS Waiver Program;

iv. Home and Community-Based Services (HCBS);

v. Local Educational Agency (LEA);

vi. Regional Center of Orange County (RCOC) ;

vii. In-Home Operations;

viii. Specialty Mental Health Services, as described in CalOptima Policy GG.1103: Specialty Mental Health Services;

ix. OCHCA Tuberculosis Program (Direct Observation Therapy); and

x. Long Term Services and Supports, including:

a) Community-Based Adult Services (CBAS);

b) In-Home Support Services (IHSS); and

c) Multipurpose Senior Services Program (MSSP).

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima and a Health Network shall include the following elements in a Member's ICP:

a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, including the following:

i. Timeframe for re-evaluation;

ii. Resources to be utilized, including the appropriate level of care;

iii. Planning for continuity of care, including transition of care and transfers between settings;

iv. Collaborative approaches to be used, including family participation; and

v. Evaluating Member's personal preferences.

b. Identification of barriers to meeting goals, or compliance with ICP:

i. Barrier analysis shall include issues such as language, or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation,

financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.

ii. Documentation of assessment for barriers, even if none identified.

c. Coordination of carved out services and referrals to appropriate community resources and agencies.

d. Facilitation of Member referrals to appropriate resources, and a follow-up process to determine whether Members act on referrals, including referrals to external resources.

e. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a Medical Management program, follow-up after referral to a health resource, and education self-management support.

i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.

ii. Documentation of the next scheduled Member contact and contact method.

f. Development and communication (e.g., orally or written) of a self-management plan that is acknowledged and agreed to by the Member. Self-management plans are actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members or their caregivers. Member self-management plan of activities includes, but is not limited to:

i. Maintaining a prescribed diet;

ii. Charting daily readings (e.g., weight, blood sugar); or

iii. Changing a wound dressing, as directed.

g. Assessment of progress towards meeting Case Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed.

h. Planning for continuity or transition of care when benefit coverage ends. CalOptima or a Health Network shall:

i. Identify transitioning Members who are receiving approved services, but whose benefit coverage will end while still needing Medically Necessary care;

ii. Identify available community resources and alternative care; and

iii. Notify and educate transitioning Members regarding alternative care and community resources.

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.

4. CalOptima or a Health Network shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.

5. CalOptima and a Health Network shall terminate Complex Case Management for a Member when the Member:

    a. Achieves ICP goals;

    b. Becomes ineligible for Case Management; or

    c. Declines Case Management.

I. Targeted Case Management (TCM)

1. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:

    a. Children under age twenty-one (21).

    b. Medically fragile individuals.

    c. Individuals at risk of institutionalization.

    d. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

    e. Individuals with a communicable disease.

2. CalOptima and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:

    a. Member is determined to be in need of case management services for non-medical needs.

    b. CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.

    c. CalOptima has determined that Member would benefit from TCM face-to-face case management.

    d. CalOptima has concerns that the Member has an inadequate support system for medical care.

    e. CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.

3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima or a Health Network.

4. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima or a Health Network.

5. For Members who have both a TCM case manager and a CalOptima or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.

J. CalOptima and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

1. MCG evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;

2. A documentation process that includes automated notation of the staff members' identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

K. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. Information regarding how CalOptima or the Health Network works with a Member in the Case Management program.

L. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's or the Health Network's Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

M. CalOptima shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Contract for Health Care Services
C. Coordination and Provision of Public Health Care Services Contract
D. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
E. CalOptima Policy GG.1103: Specialty Mental Health Services

F. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
G. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
H. CalOptima Policy GG.1352: Private Duty Nursing Care Management
I. CalOptima Policy GG.1619: Delegation Oversight
J. Case Management Society of America (CMSA): Standards of Practice for Case Management
K. National Committee for Quality Assurance (NCQA) 2021 PHM 5: Complex Case Management
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children's Service Whole Child Model Program
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
O. Title 22, California Code of Regulations (C.C.R.), §51185

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
09/09/2015	Department of Health Care Services (DHCS)
01/20/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2010	GG.1301	Case Management Process	Medi-Cal
Revised	08/01/2011	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2013	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2014	GG.1301	Complex Case Management Process	Medi-Cal
Revised	04/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	11/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	10/01/2016	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	07/01/2017	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	TBD	GG.1301	Comprehensive Case Management Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Complex Case Management	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Complex Case Management Eligible Member	Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to: 1. Spinal Injuries; 2. Transplants; 3. Cancer; 4. Serious trauma; 5. AIDS; 6. Multiple chronic illnesses; or 7. Chronic illnesses that result in high utilization. Or Member with a medical condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medical Management Program	Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff.

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Private Duty Nursing (PDN)	Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse.
Service Area	The county or counties that CalOptima is approved to operate in under the terms of the DHCS contract.
Social Determinants of Health	Economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.
Targeted Case Management	Services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

Term	Definition
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1

Policy:	GG.1313
Title:	**Coordination of Care for Transplant Members**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2000
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Case Management guidelines for coordination of care by CalOptima and a Health Network for a Member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ Transplant.

II. POLICY

A. A Transplant shall be a Covered Service in accordance with CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

B. If a Health Network Member, ~~including~~ a Whole Child Model (WCM) Member, except a Kaiser Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows:

1. Referral and Evaluation phase:

   a. CalOptima shall provide Case Management for Covered Services directly related to the Transplant referral and evaluation.

   b. The Health Network shall provide Case Management for all other Covered Services including, but not limited to, the management of ~~ventricular assistive device~~Ventricular Assistive Device (VAD) procedures, ~~dialysis~~Dialysis, and ~~transjugular intrahepatic portosystemic shunt~~Transjugular Intrahepatic Portosystemic Shunt (TIPS) procedures.

2. For Listed, Transplant, and post-Transplant phases (up to three-hundred-sixty-five (365) calendar days post-~~transplant~~Transplant): CalOptima shall provide Case Management for all Covered Services.

C. CalOptima shall be responsible for providing Case Management to a Member who is enrolled in CalOptima Direct, including a WCM Member, and who is identified as a candidate for BMT or a Solid Organ Transplant.

D. Kaiser Foundation Health Plan, Incorporated (Kaiser) shall provide Case Management to a Kaiser Member who is a potential candidate for BMT or a Solid Organ Transplant and shall assist such

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Kaiser Member with coordination of care ~~throughout~~ throughout the Transplant process in accordance with the provisions of Section III.B of this policy.

E. CalOptima shall direct a CalOptima Direct Member or a Health Network Member, except a Kaiser Member, to the appropriate Department of Health Care Services (DHCS~~-~~)-approved Transplant Center, or to a Designated Special Care Center for Members with a California Children's Services (CCS)-Eligible Condition, as ~~needed~~applicable.

1. Kaiser shall direct a Kaiser Member to the appropriate DHCS-approved Transplant Center, as needed~~-~~, or to a Designated Special Care Center for Members with a CCS-Eligible Condition, as applicable.

F. CalOptima shall provide ongoing education, collaboration, and oversight of Health Network case managers performing Case Management to a Member who is a candidate for BMT or a Solid Organ Transplant.

~~G. On or before December 31, 2018, a Member's Health Network and CalOptima shall refer a Member who is less than twenty-one (21) years of age and potentially eligible for a Transplant to California Children Services (CCS) for evaluation and authorization, in accordance with CalOptima Policy GG.1101: California Children's Services. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including transplant services.~~

III. PROCEDURE

A. If a Health Network Member~~,~~ (except a Member enrolled in Kaiser) or CalOptima Direct Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows~~:~~:

1. Referral Phase

a. A Provider shall identify a Member as a potential candidate for BMT or a Solid Organ Transplant.

i. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services ~~to~~from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals, and shall request authorization from the Member's Health Network for all other Covered Services in accordance with requirements set forth by the Health Network.

ii. If the Member is enrolled in CalOptima Direct, the Provider shall request authorization for Covered Services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

b. If a Health Network receives a request for authorization for a Transplant evaluation:

i. The Health Network shall notify the Provider to request authorization from CalOptima and shall forward the request to CalOptima's ~~Case~~Utilization Management Department within one (1) working day after receipt.

ii. The Health Network case manager shall notify the CalOptima case manager that the Member is a potential candidate for BMT or a Solid Organ Transplant by sending an

Adult Transplant Notification and Request Form by facsimile, to CalOptima's Case Management Department within:

1) Five (5) working days after identifying the Member for Routine Care; and

2) Twenty-four (24) hours or the next working day after identifying the Member for Urgent Care.

iii. The Health Network case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iv. The Health Network case manager shall complete an initial assessment and create a care plan appropriate for the Member. The Health Network case manager shall update the assessment and care plan as the Member's status changes.

c. If the Member is enrolled in CalOptima Direct, or if CalOptima receives a request for authorization for a Transplant Evaluation for a Health Network Member:

i. The CalOptima Case Management Department shall open a case for ~~case management~~Case Management.

ii. The CalOptima case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iii. After opening a Transplant case to Case Management, the CalOptima case manager shall complete an initial assessment and create a care plan appropriate for the Member. The CalOptima case manager shall update the assessment and care plan as the Member's status changes.

iv. The CalOptima case manager shall mail a Transplant information packet to the Member within five (5) working days after receipt of written notification. The case manager shall contact the Member by telephone within ten (10) working days after mailing the packet to ensure that the Member received the information and to ~~identify~~address any questions or concerns that the Member may have.

v. The CalOptima case manager will coordinate with a DHCS-approved Transplant Center or a Designated Special Care Center for Members with a CCS-Eligible Condition, to facilitate completion of the referral.

2. Evaluation Phase

a. A DHCS-approved Transplant Center or a Designated Special Care Center shall request authorization for ~~transplant~~Transplant evaluation from CalOptima. If the Health Network receives the authorization for a ~~transplant~~Transplant evaluation from the DHCS-approved

Transplant Center, or at a Designated Special Care Center the Health Network shall forward the request to the CalOptima Case Management Department within one (1) working day.

b. The CalOptima ~~Case~~Utilization Management Department shall provide authorization for a Transplant evaluation at the DHCS-approved Transplant Center or at the Designated Special Care Center, as applicable, within the following timeframes:

i. Five (5) working days after receipt of a request and information needed to make a decision regarding Medical Necessity for Routine Care; and

ii. ~~Twenty-four (24~~Seventy-two (72) hours ~~or the next working day after opening the case~~ for Urgent Care.

c. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for BMT or a Solid Organ Transplant.

The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's ~~Case~~case, to identify any issues that may prevent the Member from completing the evaluation~~.~~ and to assist

d. ~~If~~ the ~~DHCS-approved Transplant Center is unable to complete~~Member with coordinating the evaluation ~~within the ninety (90) calendar days after the Member's first evaluation appointment, the DHCS-approved Transplant Center shall notify and coordinate with the CalOptima case manager.~~.

e. Upon completion of a Member's evaluation, and approval for listing, the DHCS-approved Transplant Center or a Designated Special Care Center shall submit a Transplant Packet and request for authorization for ~~transplant~~Transplant to CalOptima for review within the following timeframes:

i. Five (5) working days after receipt of a request for Routine Care; and

ii. Twenty-four (24) hours or the next working day after receipt of a request for Urgent Care.

f. CalOptima shall notify the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and the Member's Health Network of the outcome of CalOptima's Chief Medical Officer's (CMO) or Designee's review, including CalOptima's approval or denial of the Transplant within the timeframes set forth in the CalOptima Utilization Management (UM) Program.

g. The CalOptima case manager shall verify Member eligibility on a monthly basis and shall notify the Member's Health Network case manager and the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, of any changes in the Member's eligibility.

3. Listing Phase

a. The Member's Health Network shall immediately notify CalOptima upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for BMT.

b. Upon notice from a DHCS-approved Transplant Center or a Designated Special Care Center, for a Health Network that a Member is listed for a Solid Organ Transplant or is approved for BMT, the CalOptima case manager shall notify the CalOptima Customer Service Department. The CalOptima Customer Service Department shall transition the Member to CalOptima Direct, effective the first (1st) calendar day of the month after the date CalOptima receives the above notice in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

c. The CalOptima case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and authorize Covered Services for the Member, as appropriate.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to coordinate a Member's care and identify any issues which may lead to the Member's listing being placed in Status 7 or to removal from Transplant listing.

4. Transplant Phase and Post-Transplant Phase

a. The CalOptima case manager shall follow the Member's progress during the hospital admission for the Transplant and coordinate with the facility case manager to ensure that all discharge needs are met.

b. Upon the Member's discharge, the CalOptima case manager shall provide ongoing communication with a Member as the severity and complexity of the case requires, but not less than on a monthly basis, to ~~identify~~address any issues and to assist in coordinating follow-up care.

c. CalOptima shall provide ~~case management~~Case Management for three-hundred-sixty-five (365) calendar days after the Transplant.

d. At three-hundred-sixty-five (365) calendar days post ~~transplant~~ Transplant, the CalOptima case manager shall discuss any Member issues with the Member, including selection of a Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection, and shall transition the Member's care to the Member's selected Health Network if the Member wishes to transition to a Health Network.

e. The CalOptima case manager shall close the Member's case upon:

i. The Member's transition to a Health Network; or

ii. When goals are met, or the case meets closure criteria for CalOptima Direct Members.

B. If Kaiser identifies a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant, Kaiser shall provide Case Management of the Member as follows:

1. Referral Phase

a. Kaiser is responsible for identifying a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant.

b. The Kaiser case manager shall notify the CalOptima case manager, by submitting a Notification of Transplant Member form, that the Member is a potential Transplant

candidate within five (5) working days after the Member is identified and shall open the case to ~~case management~~Case Management.

c. After opening a Transplant case to Case Management, the Kaiser case manager shall:

i. Place an introductory call to the ~~member~~Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

ii. Complete an initial assessment and create a care plan appropriate for the Member;

iii. Update the assessment and care plan as the Member's status changes; and

iv. Notify the CalOptima case manager, in writing, of any significant changes in the Member's status.

d. The CalOptima case manager shall update the medical management system and complete the ~~transplant~~Transplant reporting script for Kaiser ~~transplants~~Transplants on a monthly basis.

e. The Kaiser case manager shall mail a Transplant information packet to the Member within five (5) working days after notification. The case manager shall place a follow-up call to the Member ten (10) days after mailing the packet to ensure that the Member received the packet and to ~~identify~~address any questions or concerns that the Member may have.

2. Evaluation Phase

a. Kaiser shall direct a Kaiser Member identified as a potential candidate for BMT or a Solid Organ Transplant to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, for evaluation.

b. Kaiser shall provide authorization to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, in order to ensure that the DHCS-approved Transplant Center or the Designated Special Care Center completes the Transplant evaluation.

~~i. If If Kaiser receives notice from a DHCS-approved Transplant Center that the DHCS-approved Transplant Center is unable to complete the Transplant evaluation within ninety (90) calendar days after the Member's first (1st) appointment at the DHCS-approved Transplant Center, Kaiser shall submit a request for an extension to CalOptima.~~

~~1) Kaiser shall submit the request for an extension to CalOptima, by facsimile, no later than five (5) calendar days prior to the expiration of the required timeframe or a previously granted extension.~~

~~2) CalOptima shall review the extension request and shall notify Kaiser of its determination within five (5) working days after receipt of such request.~~

~~3) If CalOptima approves a request for extension, such extension shall be valid for thirty (30) calendar days. CalOptima may approve up to three (3) extension requests per evaluation.~~

~~4) CalOptima's CMO or Designee shall have final authority over extension determinations.~~

~~ii. If Kaiser fails to complete a Transplant Evaluation within ninety (90) calendar days after the Member's first (1st) appointment at the DHCS-approved Transplant Center or within the timeframes granted by extension, CalOptima may:~~

~~1) Place the case on Administrative Hold until an evaluation is completed; or~~

~~2) Impose Sanctions on Kaiser for non-compliance in accordance with CalOptima Policy HH.2002: Sanctions.~~

c. ~~If a DHCS-approved Transplant~~ a DHCS-approved Transplant Center or a Designated Special Care Center places a Kaiser Member on Transplant Center Hold, the Kaiser case manager shall contact the CalOptima case manager with the Member's status including reason for the Transplant Center Hold and Kaiser's plan of action to resolve the issue. The CalOptima case manager shall document this information in the Transplant database.

d. Upon completion of the Transplant evaluation, Kaiser shall review the Transplant Packet and approve or deny the ~~transplant~~Transplant in pursuant to timeframes set forth in the CalOptima UM Program.

~~e. Kaiser shall submit to CalOptima's CMO or Designee the transplant packet and outcome of its review, indicating if the requested Transplant is approved or denied, and the reasons for such determination:~~

~~i. Within one (1) working day after Kaiser renders such determination, or~~

~~ii. On the same day of receipt of a request for Urgent Care.~~

~~f. CalOptima's CMO or Designee shall review Kaiser's UM decision. If CalOptima's CMO or Designee does not agree with Kaiser's UM decision:~~

~~i. CalOptima shall notify Kaiser of the outcome of its review, indicating if the Transplant is approved or denied, within the timeframes set forth in the CalOptima UM Program.~~

~~If CalOptima's CMO or Designee does not agree with Kaiser UM decision, CalOptima shall notify Kaiser, in writing, of its decision to overrule Kaiser's UM decision within one (1) working day after making such determination.~~

~~g.~~f. The Kaiser case manager shall follow-up with the Member as the severity and complexity of the case requires, but not less than on a monthly basis, to ~~identify~~address any issues that may prevent the Member from completing the Transplant evaluation.

3. Listing Phase

a. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center for a Member who is in the listed phase or who is in Status 7 and shall authorize Covered Services related to the Transplant and the medical management of the Member.

4. Transplant Phase and Post-Transplant Phase

a. The Kaiser case manager shall follow a Member's progress during the Member's hospital admission for the Transplant, coordinate with the DHCS-approved Transplant Center's case manager or the Designated Special Care Center's case manager, to ensure that all discharge needs are met, and notify CalOptima of the Member's Transplant date within three (3) working days after the date of Transplant.

b. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or with the Designated Special Care Center and provide authorizations as needed for follow-up care.

c. The Kaiser case manager shall provide ongoing ~~case management~~Case Management of a Member as the complexity and severity of the case requires, but not less than once monthly, for three hundred sixty-five (365) calendar days after the Transplant.

d. The Kaiser case manager shall notify the CalOptima case manager, in writing, within five (5) working days after closing a case.

5. Kaiser shall submit reports to CalOptima in accordance with CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports.

IV. ATTACHMENT(S)

A. Adult Transplant Notification and Request Form

V. REFERENCE(S)

A. Contract for Health Care Provider Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
G. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy HH.2002Δ: Sanctions
K. Flow Chart: Coordination of Care for Transplant Members – CalOptima Direct and Health Networks

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/29/2016	Department of Health Care Services (DHCS)
10/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Not Applicable

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2000	GG.1313	Coordination of Care for Members Eligible for Organ Transplants and Health Network Eligibility for Transplant Service Reimbursement	Medi-Cal
Revised	11/01/2001	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	01/01/2006	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	03/01/2014	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	01/01/2016	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	09/01/2017	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	09/01/2018	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	TBD	GG.1313	Coordination of Care for Transplant Members	Medi-Cal

IX. GLOSSARY

Term	Definition
Administrative Hold	A cease in reimbursement by CalOptima for Covered Services related to a Transplant evaluation to a Health Network pending resolution of administrative issues. CalOptima's Transplant Committee reviews all Administrative Hold cases on an individual basis.
Bone Marrow Transplant (BMT)	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated ~~donor~~Donor (MUD) with human histocompatibility antigens (HL-A) that meet Department of Health Care Services (DHCS) standards.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children Services (CCS) Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a patient with special needs and or complex medical conditions that includes the elements of assessment, care planning, interventions monitoring, and documentation.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Designated Special Care Center	Centers that provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.
Designee	A person selected or designated to carry out a duty or role. The assigned ~~designee~~Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
DHCS-approved Transplant Center	A facility that is approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal ~~transplants~~Transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program; and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Dialysis	A medical procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances. This is a procedure often performed on individuals with extremely poor kidney function.
Donor	An individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant. For a BMT, the Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated ~~donor~~Donor (MUD) with human histocompatibility antigens (HL-A) that meet DHCS standards.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Member	A Member who is enrolled in~~,~~ or receives all Covered Services from a Health Network.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Foundation Health Plan.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine

Term	Definition
	Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Routine Care	Planned specialized intervention for health care needs. Routine authorization requests must meet this criterion.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.
Transjugular ~~intrahepatic portosystemic shunt~~Intrahepatic Portosystemic Shunt (TIPS)	A surgically created connection within the liver between the portal and systemic circulations. A TIPS is placed to reduce portal pressure in patients with complications related to portal hypertension.
Transplant	A non-experimental procedure for human tissue or organ ~~transplant~~Transplant.
Transplant Center Hold	Temporarily unsuitable for the evaluation process according to the DHCS-approved Transplant Center.
Transplant Packet	All clinical information related to the evaluation process of a Member who has completed his or her Transplant work-up.
Urgent Care	~~Care that is needed for an unexpected illness or injury and the service cannot be delayed. Urgent authorization requests must meet this criterion.~~An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening the disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.
Ventricular Assistive Device (VAD)	A mechanical pump that is utilized to assist the heart to pump blood through the body.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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CalOptima
Better Together

P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21, refer to California Children's Services (CCS)

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ **TIN#:** _____

Medi-Cal ID#: _____

Address: **Phone:** _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ **ICD-9:** _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

AUTHORIZATION REQUEST

☐ **Inpatient** **Estimated Length of Stay:** _____

☐ **Outpatient** ☐ **Letter of Agreement (LOA) Requested**

Date(s) of Service: _____ **Retro Date(s) of Service:** _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE — FOR CalOptima USE ONLY

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

Policy:	GG.1313
Title:	**Coordination of Care for Transplant Members**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2000
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Case Management guidelines for coordination of care by CalOptima and a Health Network for a Member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ Transplant.

II. POLICY

A. A Transplant shall be a Covered Service in accordance with CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

B. If a Health Network Member, including a Whole Child Model (WCM) Member, except a Kaiser Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows:

1. Referral and Evaluation phase:

   a. CalOptima shall provide Case Management for Covered Services directly related to the Transplant referral and evaluation.

   b. The Health Network shall provide Case Management for all other Covered Services including, but not limited to, the management of Ventricular Assistive Device (VAD) procedures, Dialysis, and Transjugular Intrahepatic Portosystemic Shunt (TIPS) procedures.

2. For Listed, Transplant, and post-Transplant phases (up to three-hundred-sixty-five (365) calendar days post-Transplant): CalOptima shall provide Case Management for all Covered Services.

C. CalOptima shall be responsible for providing Case Management to a Member who is enrolled in CalOptima Direct, including a WCM Member, and who is identified as a candidate for BMT or a Solid Organ Transplant.

D. Kaiser Foundation Health Plan, Incorporated (Kaiser) shall provide Case Management to a Kaiser Member who is a potential candidate for BMT or a Solid Organ Transplant and shall assist such Kaiser Member with coordination of care throughout the Transplant process in accordance with the provisions of Section III.B of this policy.

Back to Agenda Back to Item

E. CalOptima shall direct a CalOptima Direct Member or a Health Network Member, except a Kaiser Member, to the appropriate Department of Health Care Services (DHCS)-approved Transplant Center, or to a Designated Special Care Center for Members with a California Children's Services (CCS)-Eligible Condition, as applicable.

1. Kaiser shall direct a Kaiser Member to the appropriate DHCS-approved Transplant Center, as needed, or to a Designated Special Care Center for Members with a CCS-Eligible Condition, as applicable.

F. CalOptima shall provide ongoing education, collaboration, and oversight of Health Network case managers performing Case Management to a Member who is a candidate for BMT or a Solid Organ Transplant.

III. PROCEDURE

A. If a Health Network Member (except a Member enrolled in Kaiser) or CalOptima Direct Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows:

1. Referral Phase

a. A Provider shall identify a Member as a potential candidate for BMT or a Solid Organ Transplant.

i. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals, and shall request authorization from the Member's Health Network for all other Covered Services in accordance with requirements set forth by the Health Network.

ii. If the Member is enrolled in CalOptima Direct, the Provider shall request authorization for Covered Services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

b. If a Health Network receives a request for authorization for a Transplant evaluation:

i. The Health Network shall notify the Provider to request authorization from CalOptima and shall forward the request to CalOptima's Utilization Management Department within one (1) working day after receipt.

ii. The Health Network case manager shall notify the CalOptima case manager that the Member is a potential candidate for BMT or a Solid Organ Transplant by sending an Adult Transplant Notification and Request Form by facsimile, to CalOptima's Case Management Department within:

1) Five (5) working days after identifying the Member for Routine Care; and

2) Twenty-four (24) hours or the next working day after identifying the Member for Urgent Care.

iii. The Health Network case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iv. The Health Network case manager shall complete an initial assessment and create a care plan appropriate for the Member. The Health Network case manager shall update the assessment and care plan as the Member's status changes.

c. If the Member is enrolled in CalOptima Direct, or if CalOptima receives a request for authorization for a Transplant Evaluation for a Health Network Member:

i. The CalOptima Case Management Department shall open a case for Case Management.

ii. The CalOptima case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iii. After opening a Transplant case to Case Management, the CalOptima case manager shall complete an initial assessment and create a care plan appropriate for the Member. The CalOptima case manager shall update the assessment and care plan as the Member's status changes.

iv. The CalOptima case manager shall mail a Transplant information packet to the Member within five (5) working days after receipt of written notification. The case manager shall contact the Member by telephone within ten (10) working days after mailing the packet to ensure that the Member received the information and to address any questions or concerns that the Member may have.

v. The CalOptima case manager will coordinate with a DHCS-approved Transplant Center or a Designated Special Care Center for Members with a CCS-Eligible Condition, to facilitate completion of the referral.

2. Evaluation Phase

a. A DHCS-approved Transplant Center or a Designated Special Care Center shall request authorization for Transplant evaluation from CalOptima. If the Health Network receives the authorization for a Transplant evaluation from the DHCS-approved Transplant Center, or at a Designated Special Care Center the Health Network shall forward the request to the CalOptima Case Management Department within one (1) working day.

b. The CalOptima Utilization Management Department shall provide authorization for a Transplant evaluation at the DHCS-approved Transplant Center or at the Designated Special Care Center, as applicable, within the following timeframes:

i. Five (5) working days after receipt of a request and information needed to make a decision regarding Medical Necessity for Routine Care; and

ii. Seventy-two (72) hours for Urgent Care.

c. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for BMT or a Solid Organ Transplant.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to identify any issues that may prevent the Member from completing the evaluation and to assist the Member with coordinating the evaluation.

e. Upon completion of a Member's evaluation, and approval for listing, the DHCS-approved Transplant Center or a Designated Special Care Center shall submit a Transplant Packet and request for authorization for Transplant to CalOptima for review within the following timeframes:

i. Five (5) working days after receipt of a request for Routine Care; and

ii. Twenty-four (24) hours or the next working day after receipt of a request for Urgent Care.

f. CalOptima shall notify the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and the Member's Health Network of the outcome of CalOptima's Chief Medical Officer's (CMO) or Designee's review, including CalOptima's approval or denial of the Transplant within the timeframes set forth in the CalOptima Utilization Management (UM) Program.

g. The CalOptima case manager shall verify Member eligibility on a monthly basis and shall notify the Member's Health Network case manager and the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, of any changes in the Member's eligibility.

3. Listing Phase

a. The Member's Health Network shall immediately notify CalOptima upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for BMT.

b. Upon notice from a DHCS-approved Transplant Center or a Designated Special Care Center, for a Health Network that a Member is listed for a Solid Organ Transplant or is approved for BMT, the CalOptima case manager shall notify the CalOptima Customer Service Department. The CalOptima Customer Service Department shall transition the Member to CalOptima Direct, effective the first (1st) calendar day of the month after the date CalOptima receives the above notice in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

c. The CalOptima case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and authorize Covered Services for the Member, as appropriate.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to coordinate a Member's care and identify

any issues which may lead to the Member's listing being placed in Status 7 or to removal from Transplant listing.

4. Transplant Phase and Post-Transplant Phase

a. The CalOptima case manager shall follow the Member's progress during the hospital admission for the Transplant and coordinate with the facility case manager to ensure that all discharge needs are met.

b. Upon the Member's discharge, the CalOptima case manager shall provide ongoing communication with a Member as the severity and complexity of the case requires, but not less than on a monthly basis, to address any issues and to assist in coordinating follow-up care.

c. CalOptima shall provide Case Management for three-hundred-sixty-five (365) calendar days after the Transplant.

d. At three-hundred-sixty-five (365) calendar days post-Transplant, the CalOptima case manager shall discuss any Member issues with the Member, including selection of a Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection, and shall transition the Member's care to the Member's selected Health Network if the Member wishes to transition to a Health Network.

e. The CalOptima case manager shall close the Member's case upon:

i. The Member's transition to a Health Network; or

ii. When goals are met, or the case meets closure criteria for CalOptima Direct Members.

B. If Kaiser identifies a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant, Kaiser shall provide Case Management of the Member as follows:

1. Referral Phase

a. Kaiser is responsible for identifying a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant.

b. The Kaiser case manager shall notify the CalOptima case manager, by submitting a Notification of Transplant Member form, that the Member is a potential Transplant candidate within five (5) working days after the Member is identified and shall open the case to Case Management.

c. After opening a Transplant case to Case Management, the Kaiser case manager shall:

i. Place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

ii. Complete an initial assessment and create a care plan appropriate for the Member;

iii. Update the assessment and care plan as the Member's status changes; and

iv. Notify the CalOptima case manager, in writing, of any significant changes in the Member's status.

d. The CalOptima case manager shall update the medical management system and complete the Transplant reporting script for Kaiser Transplants on a monthly basis.

e. The Kaiser case manager shall mail a Transplant information packet to the Member within five (5) working days after notification. The case manager shall place a follow-up call to the Member ten (10) days after mailing the packet to ensure that the Member received the packet and to address any questions or concerns that the Member may have.

2. Evaluation Phase

a. Kaiser shall direct a Kaiser Member identified as a potential candidate for BMT or a Solid Organ Transplant to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, for evaluation.

b. Kaiser shall provide authorization to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, in order to ensure that the DHCS-approved Transplant Center or the Designated Special Care Center completes the Transplant evaluation.

c. If a DHCS-approved Transplant Center or a Designated Special Care Center places a Kaiser Member on Transplant Center Hold, the Kaiser case manager shall contact the CalOptima case manager with the Member's status including reason for the Transplant Center Hold and Kaiser's plan of action to resolve the issue. The CalOptima case manager shall document this information in the Transplant database.

d. Upon completion of the Transplant evaluation, Kaiser shall review the Transplant Packet and approve or deny the Transplant in pursuant to timeframes set forth in the CalOptima UM Program.

f. The Kaiser case manager shall follow-up with the Member as the severity and complexity of the case requires, but not less than on a monthly basis, to address any issues that may prevent the Member from completing the Transplant evaluation.

3. Listing Phase

a. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center for a Member who is in the listed phase or who is in Status 7 and shall authorize Covered Services related to the Transplant and the medical management of the Member.

4. Transplant Phase and Post-Transplant Phase

a. The Kaiser case manager shall follow a Member's progress during the Member's hospital admission for the Transplant, coordinate with the DHCS-approved Transplant Center's case manager or the Designated Special Care Center's case manager, to ensure that all discharge needs are met, and notify CalOptima of the Member's Transplant date within three (3) working days after the date of Transplant.

b. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or with the Designated Special Care Center and provide authorizations as needed for follow-up care.

c. The Kaiser case manager shall provide ongoing Case Management of a Member as the complexity and severity of the case requires, but not less than once monthly, for three hundred sixty-five (365) calendar days after the Transplant.

d. The Kaiser case manager shall notify the CalOptima case manager, in writing, within five (5) working days after closing a case.

5. Kaiser shall submit reports to CalOptima in accordance with CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports.

IV. ATTACHMENT(S)

A. Adult Transplant Notification and Request Form

V. REFERENCE(S)

A. Contract for Health Care Provider Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
G. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy HH.2002Δ: Sanctions
K. Flow Chart: Coordination of Care for Transplant Members – CalOptima Direct and Health Networks

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/29/2016	Department of Health Care Services (DHCS)
10/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Not Applicable

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2000	GG.1313	Coordination of Care for Members Eligible for Organ Transplants and Health Network Eligibility for Transplant Service Reimbursement	Medi-Cal
Revised	11/01/2001	GG.1313	Coordination of Care for Transplant Members	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2006	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	03/01/2014	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	01/01/2016	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	09/01/2017	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	09/01/2018	GG.1313	Coordination of Care for Transplant Members	Medi-Cal
Revised	TBD	GG.1313	Coordination of Care for Transplant Members	Medi-Cal

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IX. GLOSSARY

Term	Definition
Administrative Hold	A cease in reimbursement by CalOptima for Covered Services related to a Transplant evaluation to a Health Network pending resolution of administrative issues. CalOptima's Transplant Committee reviews all Administrative Hold cases on an individual basis.
Bone Marrow Transplant (BMT)	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated Donor (MUD) with human histocompatibility antigens (HL-A) that meet Department of Health Care Services (DHCS) standards.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children Services (CCS) Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a patient with special needs and or complex medical conditions that includes the elements of assessment, care planning, interventions monitoring, and documentation.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Designated Special Care Center	Centers that provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
DHCS-approved Transplant Center	A facility that is approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal Transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program; and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Dialysis	A medical procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances. This is a procedure often performed on individuals with extremely poor kidney function.
Donor	An individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant. For a BMT, the Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated Donor (MUD) with human histocompatibility antigens (HL-A) that meet DHCS standards.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Member	A Member who is enrolled in or receives all Covered Services from a Health Network.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Foundation Health Plan.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services

Term	Definition
	(DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Routine Care	Planned specialized intervention for health care needs. Routine authorization requests must meet this criterion.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.
Transjugular Intrahepatic Portosystemic Shunt (TIPS)	A surgically created connection within the liver between the portal and systemic circulations. A TIPS is placed to reduce portal pressure in patients with complications related to portal hypertension.
Transplant	A non-experimental procedure for human tissue or organ Transplant.
Transplant Center Hold	Temporarily unsuitable for the evaluation process according to the DHCS-approved Transplant Center.
Transplant Packet	All clinical information related to the evaluation process of a Member who has completed his or her Transplant work-up.
Urgent Care	An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening the disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.
Ventricular Assistive Device (VAD)	A mechanical pump that is utilized to assist the heart to pump blood through the body.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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CalOptima
Better Together

P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21, refer to California Children's Services (CCS)

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ **TIN#:** _____

Medi-Cal ID#: _____

Address: **Phone:** _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ **ICD-9:** _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

AUTHORIZATION REQUEST

☐ **Inpatient** **Estimated Length of Stay:** _____

☐ **Outpatient** ☐ **Letter of Agreement (LOA) Requested**

Date(s) of Service: _____ **Retro Date(s) of Service:** _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE — FOR CalOptima USE ONLY

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

29. Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer (714) 246-8887
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the contract with Infomedia Group, Inc., dba Carenet Healthcare Services (Carenet), to include reimbursement for member engagement services to support timely communications to CalOptima Community Network (CCN) members, as well as correct the term section of the contract to align with the Request for Proposal (RFP) to reflect a three year term, along with two one year extension options, each exercisable at CalOptima's sole discretion.

Background

In 2019, CalOptima issued an RFP for a vendor to manage the 24/7 Nurse Advice Line, and after-hours calls for the Customer Service and Behavioral Health Integration departments. Carenet was selected through the RFP process, and CalOptima entered into a contract with an annual renewal pending Board approval. The contract took effect on July 1, 2019 and provides for annual extensions.

Under the existing agreement, Carenet offers 2,000 live outreach calls per fiscal year. Due to the COVID-19 pandemic, more residents in Orange County are eligible for Medi-Cal benefits. As a result, CalOptima's Medi-Cal membership has grown to over 820,000 members.

To promote timely member outreach, support CalOptima's ability to reach members by telephone and help close the gap caused by the digital divide, additional member outreach support efforts are recommended. Therefore, CalOptima staff requests authorization to amend the contract with Carenet to include reimbursement for member engagement calls beyond the 2,000 per fiscal year included in the current contract to support timely communications to CalOptima Community Network (CCN) members.

Discussion

In the past, staff leveraged Carenet's outbound calls to welcome CalOptima's CCN members and encourage them to schedule preventive services with their primary care providers. Expanding the scope of these calls to include other member outreach engagement activities is expected to assist CalOptima in improving health care outcomes for members. Increased member outreach will support the organization in closing quality in care gaps, identifying health equity trends and outcomes impacted by social determinants of health (SDoH).

In addition, because the Centers for Medicare & Medicaid Services uses a five-star quality rating system ("Star Rating Program") to measure CalOptima's health care system quality and member experience, staff believes it is important to continue robust member engagement and outreach activities. Outreach through Carenet, to engage with CalOptima's membership is an important part of this effort.

Back to Agenda

As proposed, Carenet's Engagement Specialists will conduct live outreach to the identified CalOptima members for a variety of interactions, including but not limited to:

- COVID-19 Vaccine member appointment scheduling
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Blood Lead Screening
- Health Information Forms and Initial Health Assessments (HIF/IHA)
- Annual well visits (which impact Star Rating Program measures and other gaps in care)

To provide timely member engagement activities and inform members of important initiatives, CalOptima staff recommends that the Board authorize the proposed amendment to the Carenet contract to expand the outreach call services, effective June 3, 2021.

In addition to adding additional outreach services, the proposed amendment corrects an error in the term of the contract, which did not match the term advertised in the RFP. To align with the term referenced in the RFP, the amendment corrects the term section of the contract to include a three-year (3) contract, with two additional one-year (1) extensions pending Board approval.

Fiscal Impact

Budgeted funds for member engagement services under the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020, is sufficient to cover the estimated expenses associated with the contract amendment for the period of June 3, 2021, through June 30, 2021.

Management will include funding for the recommended action in the proposed Fiscal Year 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation

Staff recommends Board authorization of a contract amendment with Carenet to provide timely outreach communications to members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Proposed Contract Amendment with Carenet
3. Existing Carenet Ancillary Services Contract

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Infomedia Group, Inc., dba Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230

AMENDMENT I TO
ANCILLARY SERVICES CONTRACT

THIS AMENDMENT I TO THE ANCILLARY SERVICES CONTRACT ("Amendment I") shall be effective----------, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Infomedia Group, Inc., dba Carenet Healthcare Services** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract, by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend this Contract to replace the Term section of the Contract and include Member Engagement Services.

NOW, THEREFORE, the parties agree as follows:

1. Section 7.1 "Term" shall be deleted in its entirety and replaced with the following:

   "7.1 Term. This Contract will commence on July 1, 2019 ("Effective Date") and will remain in effect until June 30, 2022. This Contract may be renewed at CalOptima's option for two additional one-year periods."

2. ATTACHMENT A, COVERED SERVICES shall be deleted in its entirety and replaced with the new ATTACHMENT A, COVERED SERVICES attached herein.

3. ATTACHMENT C, COMPENSATION shall be deleted in its entirety and replaced with the new ATTACHMENT C, COMPENSATION attached herein.

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment I, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment I.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
Print Name	Ladan Khamseh Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

X	Medi-Cal Program
X	Medicare Advantage Program (OneCare)
	PACE Program
X	Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

ARTICLE 2
SERVICES

SCOPE OF WORK

1. NURSE ADVICE LINE

Provider shall provide the following services:

- Customer service support for Call Center to CalOptima's Members and providers
- Customer service and clinical support for Behavioral Health Line to CalOptima Members and providers
- Customer service and clinical support for Nurse Advice Line to CalOptima's Members
- Engagement Strategies to support welcome calls, program reminders, notifications

Provider shall perform all service level guarantees and requirements per the RFP.

2. MEMBER ENGAGEMENT

The services will only be provided at the direction of CalOptima, using approved CalOptima scripts, and only to numbers that CalOptima has certified as meeting the requirements of the Telephone Consumer Protection Act (TCPA), 42 U.S.C., Section 227.

2.1 PROGRAM OVERVIEW

The program shall consist of outbound telephonic and other engagement activities for CalOptima Members. This will include, but will not be limited to, COVID-19 outreach, welcome/onboarding calls, telephonic health assessments, appointment facilitation to address HEDIS measures, Risk Adjustment, or other gaps in care, post-discharge, or other outreach initiatives.

2.1.1 Provider shall perform 2,000 live outreach calls to the identified CalOptima Members per fiscal year.
2.1.2 Provider shall attempt to reach each Member a maximum of three times.
2.1.3 Hours of Operation will be 8 am to 9 pm Pacific Standard Time, Monday through Saturday.
2.1.4 CalOptima shall send Provider eligible Member demographic information.
2.1.5 Provider shall provide CalOptima with standard reports and a data extract with all call details.
2.1.6 For COVID-19 outreach, Provider shall make warm transfers to CalOptima to schedule vaccination with the Member.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Nurse Advice Line:

CalOptima shall reimburse for Covered Services as follows:

$XX PMPM

II. Member Engagement:

If CalOptima requests over 2,000 live outbound calls per fiscal year, CalOptima shall reimburse for Covered Services as follows:

$XX per call

Provider shall not charge and CalOptima will not reimburse for the first 2,000 live outbound calls to the identified CalOptima Members per fiscal year.

Provider shall not charge and CalOptima shall not reimburse for invalid numbers (disconnected, bad, fax, etc.)

Any invalid numbers shall not count as part of the 2,000 calls per fiscal year, for which there is no separate charge, and for which CalOptima shall not reimburse.

III. Payment Procedures:

Provider shall bill with the assigned purchased order, and invoice shall include a Unique Member Engagement Outreach Monthly Totals.

CalOptima agrees to make a payment within thirty (30) business days from receipt of an invoice services provided by Provider under this contract.

ANCILLARY SERVICES CONTRACT

NON-MEDICAL PROVIDER

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Infomedia Group, Inc. dba Carenet Healthcare Services** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("DHHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima has entered into an agreement with the California Department of Aging to operate as a program site under the Multipurpose Senior Services Program, a case management program with the goal of avoiding or delaying inappropriate placement of persons in nursing facilities, while fostering independent living in the community, as provided by Welfare and Institutions Code section 9560 et seq. As a program site, CalOptima is responsible for arranging for MSSP services for certain CalOptima members.

H. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children Services Program" or "CCS" means a public health program, which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), and Section 41800.

1.3 "CDA" means the California Department of Aging.

1.4 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.4.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.4.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.5 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.6 "CalOptima Programs" means the Medi-Cal, OneCare, Multipurpose Senior Service Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.7 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.8 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.9 "Clean Claim" means a Claim or invoice that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.10 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.11 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of

its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.12 "Covered Services" means those items and services available to Members set forth in Attachment A of this Contract.

1.13 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.14 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.15 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, and their respective agents and contractors, including quality improvement organizations (QIOs).

1.16 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.17 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.18 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.19 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.20 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.*, the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.21 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.22 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.23 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.24 "MSSP" means Multipurpose Senior Services Program, as provided by W&I section 9560 et seq.

1.25 "Participation Status" means whether or not a person or entity is or has been suspended or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.26 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a. All Medicare-covered items and services
b. All Medi-Cal covered items and services; and
c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.27 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.28 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 Provider shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.8 Disclosure of Provider Ownership. Provider shall complete Attachment D and provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.9 Quality Improvement Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by its ancillary health services providers and suppliers. Provider agrees that it is subject to the requirements of CalOptima's Quality Improvement Program ("QI Program") and that it shall participate in QI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima's Quality Improvement Organization ("QIO") including, without limitation, to resolve Member complaints.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638

2.10 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.11 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.12 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff and Subcontractors attitudes and interpersonal communication styles which respect Members' cultural backgrounds. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

2.13 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding arranging for the provision of non-medical services treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.14 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.15 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or Provider. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or Provider as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.16 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed, or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.17 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and

applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.18 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies

2.19 Reporting Obligations. Provider shall submit such reports and data required by CalOptima for the CalOptima Programs.

2.20 Subcontracting of Covered Services. Provider shall not subcontract for any Covered Services without the prior approval of CalOptima. Any subcontracting approved by CalOptima is subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all

Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.20.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.20.2 An agreement to maintain such books and records in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies.

2.20.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.20.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other customers.

2.20.5 An agreement to comply with CalOptima's Compliance Program.

2.20.6 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.21 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.22 Participation Status. Provider shall have policies and procedures to verify the Participation Status of Provider's Agents. In addition, Provider warrants and agrees as follows:

2.22.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.22.2 Provider shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.22.4 Provider shall take immediate action to remove any Provider Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members.

2.22.5 Provider shall include the obligations of this Section in its Subcontracts.

2.23 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be reviewed to confirm that required Licenses and other applicable qualifications are met. to the extent required by CalOptima Policy.

2.24 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.25 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.26 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.27 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.28 Facility Construction or Repair. When applicable for purposes of construction or repair of facilities, Provider shall comply with the provisions in the following acts and/or will include such provisions in any applicable Subcontracts:

- Copeland "Anti-Kickback" Act (18 USC 874, 40 USC 2760) (29 CFR, Part 3)
- Davis-Bacon Act (40 USC 276a-7) (29 CFR, Part 5)
- Contract Work Hours and Safety Standards Act (40 USC 327-330) (29 CFR, Part 5)
- Executive Order 1126 of September 14, 1965 entitled, "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations (41 CFR, Part 60).

When Provider's agreement provides funding for both construction and non-construction activities, Provider shall obtain prior written approval from CalOptima before making any fund or budget transfers between construction and non-construction.

2.29 Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

2.29.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

2.29.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

2.29.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

2.29.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Sub provision 13.1.2 herein; and

2.29.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2.29.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

2.29.1.6 Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

2.29.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

2.29.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

2.29.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

2.30 Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in this Addendum 1.

2.30.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

2.30.2 Certification and Disclosure Requirements

2.30.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.29.3 of this provision.

2.30.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.29.3 of this provision if paid for with appropriated funds.

2.30.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.29.2.2 herein. An event that materially affects the accuracy of the information reported includes:

2.30.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

2.30.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

2.30.2.3.3 A change in the officer(s), employee(s), or member(s) contacted

for the purpose of influencing or attempting to influence a covered federal action.

2.30.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.28.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.30.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.28.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

2.30.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2.31 Provider's Agent's Qualifications. Provider shall verify the qualifications of all Provider's Agents providing services under this Contract consistent with the services to be provided, as further described in the attached "scope of Work." In addition, for Provider's Agents that enter into Members' homes or have face-to-face contact with Members, Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Provider shall comply with all applicable laws in conducting background investigations, and shall exclude unqualified Agents from providing services under this Contract.

2.32 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to CalOptima Health Networks the same terms regarding Provider performance, duties and obligations and rates for Ancillary Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim or invoice, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C.

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies Procedures as may be amended from time to time. .

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

ARTICLE 4
PAYMENT PROCEDURES

4.1 Billing and Claims Submission. Provider shall submit Claims or invoices for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 Member Financial Protections. Provider shall comply with Member financial protections as follows:

4.5.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract.

4.5.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such

identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.6.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.6.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

If providing Professional Services under this contract, the Vendor at its sole cost and expense, shall maintain a Professional Liability Insurance policy covering itself and any Subcontractors with minimum limits as follows:

Professional Liability providing Covered Services: $1,000,000 per incident/$2,000,000 aggregate

5.2.2 Commercial General Liability/Commercial Automobile Liability:

Vendor, at its sole cost and expense shall maintain a Commercial General Liability and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: (Including Personal Injury) $1,000,000 per occurrence/$2,000,000 aggregate

Commercial Automobile Liability: * $1,000,000 Combined Single Limit

Additional insured wording is required on both policies as well as primary and non-contributory wording and Waiver of Subrogation. Additional Insured wording to include: Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

*(Charter-party carriers of passengers:)

If applicable, vendor shall comply with the Public Utilities Commission (PUC) General Order No. 115-G, which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

$ 1,500,000 if seating capacity is 8-15

$ 5,000,000 if seating capacity is over 15 unless otherwise amended by future regulations.

In the case of a charter-party carrier with seating capacity of 7 or less, CalOptima will require $1,000,000 Combined Single Limit.

5.2.3 Workers' Compensation:

Vendor, at its sole cost and expense shall maintain a Workers' Compensation Insurance policy as required by the State of California with minimum limits as follows:

Employers' Liability Insurance:	$1,000,000 Bodily injury each accident
	$1,000,000 Bodily injury policy limit
	$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

5.2.4 Commercial Crime:

If applicable, Vendor, at its sole cost and expense shall maintain a commercial crime policy covering theft and dishonesty, forgery and alterations, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property as follows:

Commercial Crime Insurance: $1,000,000 per occurrence

5.2.5 Cyber and Privacy Liability Insurance:

If applicable, Vendor shall maintain the following minimum coverages for such length of time as necessary to cover any and all claims:

Cyber and Privacy Liability Insurance: $1,000,000 each coverage
(including Privacy and Network Liability;
Internet Media Liability;
Business Interruption and Expense;
Data Extortion;
Regulatory Proceeding; and
Data Breach Notification & Credit Monitoring)

5.2.6 Bonding:

If providing services which require bonding, Vendor shall be bonded at amounts usual or customary in Vendor's industry and type of service.

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with rating of A- VII or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.4 Captive Risk Retention Group/Self Insured:

Where any of the insurances mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.3 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

5.5 Cancellation or Material Change:

The vendor shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

Certificates of Insurance of the above insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

5.7 Subcontractors:

Vendor shall require each of its Subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

5.8 Failure or refusal to maintain or produce proof of Insurance:

If Vendor fails or refuses to maintain or produce proof of the insurance required by Section 5.2, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect Vendor's right to be paid for its time and materials expended prior to notification of termination. Vendor waives the right to receive compensation and agrees to indemnity CalOptima for any work performed prior to approval of Insurance by CalOptima.

5.9 Other Liability:

Neither party shall be liable to the other for any indirect, exemplary, special, punitive, consequential or incidental damages or loss of goodwill, data or profits, or cost of cover.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.3 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.4. Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.4.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.4.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4.3 Declaration of Confidentiality. If Provider has access to computer files or any data confidential by statute, including identification of eligible members, Provider agrees to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30th, 2020. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the

provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, permits and certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for

approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. Provider and/or Subcontractor complaints, concerns or differences shall be resolved through the mechanisms set forth in CalOptima Policies related to the applicable CalOptima Program(s).

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits, as well as Provider's response to the CalOptima's Request for Proposal (RFP) and any further information or clarification submitted as part of the RFP process, and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder. In the event of any inconsistency between the RFP and this Contract, the terms and provisions of this Contract shall govern and control.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:
Carenet Healthcare Services
Attn: Stacie Stoner, VP Client Services
11845 IH-10 West, Suite 400
San Antonio, TX 78230

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Provider covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on July 1st, 2019 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
Signature	Signature
Vikie Spulak	Ladan Khamseh
Print Name	Print Name
Chief Client Officer	Chief Operating Officer
Title	Title
June 4, 2019	6/19/2019
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

___X___ Medi-Cal Program

___X___ Medicare Advantage Program (OneCare)

_____ PACE Program

___X___ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

_____ Multipurpose Senior Services Program (MSSP)

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means those items and services as defined under applicable CalOptima Programs and CalOptima Policies and required to be furnished under this Contract, and provided to Members who are authorized to receive such items and services including:

Call Center Support and Nurse Triage Services

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

1.1 Cal Optima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) and PACE with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD and PACE Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

2. HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. **Medi-Cal Program Reimbursement**
For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

[redacted]

II. **Medicare Advantage (OneCare) Program Reimbursement**
For Medicare Advantage (OneCare) Members, CalOptima shall reimburse for Covered Services as follows:

[redacted]

III. **PACE Program Reimbursement**
For PACE Members, CalOptima shall reimburse for Covered Services as follows:

N/A

IV. **Cal MediConnect (OneCare Connect) Program Reimbursement**
For Cal MediConnect (OneCare Connect) Members, CalOptima shall reimburse for Covered Services as follows:

[redacted]

V. **MSSP Program Reimbursement**
Invoicing and Rates. Upon receipt of Clean Claim or invoice, CalOptima shall pay Provider, within 30 days, for services authorized the previous month. CalOptima shall pay Provider at rates in Attachment C, pursuant to CalOptima Policies and Procedures, as may be amended from time to time. Provider will not be paid for time required for Provider to travel to or from the Member's home, unless travel is included as part of the Authorized Services provided, e.g. shopping or transportation/escort. In such instances, Provider may also request reimbursement for mileage at the current CalOptima reimbursement rate. Provider shall submit to CalOptima each month an invoice referencing a Service Authorization Form (SAF) number for Authorized Services provided the prior month. Invoices are due within 15 days after the end of the month in which Authorized Services were provided. Invoices not submitted within 90 days of the month of service will not be paid. Invoices shall be sent to: CalOptima, Senior Select Program/MSSP, 505 City Parkway West, Orange, CA, 92868.

N/A

ATTACHMENT D

DISCLOSURE FORM

Infomedia Group, Inc. dba Carenet Healthcare Services

Name of Provider

The undersigned hereby certifies that the following information regarding

Infomedia Group, Inc. dba Carenet Healthcare Services (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
John Erwin, Director
John Erwin, Scott Schawe, Mick Mazour and Vikie Spulak Officers.

Co-Owner(s):
John Erwin

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
Not Applicable

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
Not Applicable

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
Corporation

Dated: June 6, 2019

Signature: 

Name: Vikie Spulak
(Please type or print)

Title: CCO
(Please type or print)

ATTACHMENT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

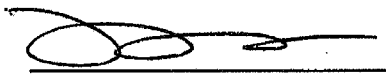
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.
This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Infomedia Group, Inc. dba Carenet Healthcare Services	Vikie Spulak
Name of Contractor	Printed Name of Person Signing for Contractor
	
Contract / Grant Number	Signature of Person Signing for Contractor
June 6, 2019	CCO
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Back to Agenda Back to Item

ATTACHMENT E-1 N/A

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, If known:	9. Award Amount, If known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment Indicated In Item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider and its Subcontractors shall maintain and retain all records of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records.

   2.1 Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying by CalOptima, DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), or their designees, at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

   2.2 Through the end of the records retention period specified in Section 2.1, above, Provider shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the

Comptroller General of the United States, CDA, Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Provider pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 2.1, above, Provider shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Provider's sole expense.

2.3 Authorized State and Federal agencies will have the right to monitor all aspects of Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Provider's facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Provider. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Provider will provide and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Provider or its Subcontractor(s).

2.4 Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

2.5 This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

5. Assignment and Delegation. Except as specifically permitted hereunder, this Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior

written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

6. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

7. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

8. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

9. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to the

CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

11.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

11.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

11.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Provider agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, DHHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

   (b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set forth in this Contract. Moreover, CalOptima shall have the right to require Provider to terminate any Subcontracting provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

4. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the Encounter Data.

ADDENDUM 3

PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 3 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2 Amendments to this Contract and amendments to any subcontract agreements between Provider and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees. Provider shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1 Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2 Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3 Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   2.5 Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants

to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

2.6 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

2.7 Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8 Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9 Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including Encounter Data, of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, CDA, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

7. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

8. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against

CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

9. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

11.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

11.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

11.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

11.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

ADDENDUM 4
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Provider shall provide services in accordance with applicable DHCS and CMS laws, regulations, instructions, and contractual obligations with CalOptima.

2. Provider shall (1) comply with the confidentiality and laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintain the records and information in an accurate and timely manner, and (4) ensure timely access by enrollees to the records and information that pertain to them, and (5) comply with all DHCS and CMS confidentiality requirements.

3. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

4. Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.

5. Provider shall submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

7. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and shall be responsible for any resulting overpayments.

8. Downstream Entity Contracts. If any services under this Contract are to be provided by a Downstream Entity Contracts subcontracted by Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract.

9 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

ADDENDUM 5
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

The terms and requirements of this Addendum 5 shall apply for services provided by Provider to Members who are enrolled in the CalOptima Multipurpose Senior Services Program.

1. MSSP Site Manual. is the Multipurpose Senior Services Program (MSSP) Site Manual, dated July 1, 1992, produced by the CDA, and all subsequent amendments and revisions. Provider shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA Medi-Cal Services Branch, including any subsequent changes to State and Federal Law.

2. Vendor Application Form. Provider shall complete a CDA-approved Vendor Application Form. Provider shall submit to CalOptima any changes to the information contained in the Vendor Application Form within 15 days of any change.

3. Training/Education. Provider agrees to provide ongoing education and training, at least annually, for all employees and Subcontractors who handle personal, sensitive or confidential information. Provider employees and Subcontractors will complete the Security Awareness Training module located on the Department of Aging's website, www.aging.ca.gov, within 30 days of the start date of this Contract, or within 30 days of the start date of any new employee or Subcontractor. Provider may substitute its own Security Training program for CDA's Security Awareness Training program, provided such training meets or exceeds CDA's training requirement. Provider shall maintain documentation of training and education provided to their staff and/or Subcontractors. All employees, volunteers and Subcontractors who handle personal, sensitive or confidential information relating to CDA's programs must participate in Security Awareness Training.

4. Provider Confidentiality Statement. The Provider shall sign and return a Contractor/Vendor Confidentiality Statement (CDA 1024 Form) with this Contract. This is to ensure that Contractor/Vendors are aware of, and agree to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

5. Travel Reimbursement Limits. In the event that this Contract provides for the reimbursement of authorized travel, any reimbursement for such authorized travel shall be at a rate not to exceed those amounts paid by the State in accordance with the Department of Personnel Administration's rules and regulations, which may be found at http://www.dpa.ca.gov/textdocs/freepmls/PML2008019.pdf (generally), http://www.dpa.ca.gov/personnel-policies/travel/meals-and-incidentals.htm (per diem), and http://www.dpa.ca.gov/personnel-policies/travel/short-term-travel.htm (lodging). This is not to be construed as limiting Provider from paying any differences in costs, from funds not derived from MSSP, between the Department of Personnel Administration rates and any rates Provider is obligated to pay under other contractual agreements. No travel outside of the State of California shall be reimbursed, unless prior written authorization from the State is obtained (CCR, Title 2, Section 599.615 et seq.).

6. The Provider shall maintain complete records (which shall include, but not be limited to, accounting records, contracts, agreements, letters of agreement, insurance documentation in accordance with Article XII., Memoranda and/or Letters of Understanding, and patient records) of its activities and expenditures hereunder in a form satisfactory to CDA, and shall make all records pertaining to this Contract available for inspection and audit by CalOptima and the State, or either's duly authorized agents, at any time during normal business hours. All such records must be maintained and made available by the Provider; (a) until an audit has occurred and an audit resolution has been issued, or unless otherwise authorized in writing by CDA or DHCS' Audit Branch, (b) for such longer period, if any, as is required by applicable statue, by any other clause of this Contract, or (c) for such longer period as CDA deems necessary.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
30. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

Contacts
Ladan Khamseh, Chief Operating Officer (714) 246-8866
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Action
Approve modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting [Medi-Cal, OneCare, OneCare Connect]

Background
CalOptima is obligated to comply with Department of Health Care Services (DHCS) Medi-Cal contractual provisions and All Plan Letter guidance addressing federal Medicaid regulatory requirements for the submission of data and reports. CalOptima is also obligated to comply with the Centers for Medicare & Medicaid Services (CMS) contractual provisions and regulatory guidance addressing Medicare requirements for the submission of data and reports. CalOptima Policy HH.2003: *Health Network and Delegated Entity Reporting* has been in place since 1998 to provide guidance to staff, Health Networks, and Delegated Entities regarding Medi-Cal, Medicare and CalOptima's reporting requirements. The policy is used by staff responsible for conducting monitoring of Health Network and Delegated Entity reporting. The policy provides guidelines for conducting outreach, monitoring, and escalating non-compliance with reporting requirements.

This Policy impacts CalOptima's Medi-Cal, OneCare, and OneCare Connect programs. Policy HH.2003 requires that each Health Network or other delegated entity submit noted reports to CalOptima, as specified in its contract with CalOptima and the Policy's Attachment A: Timely and Appropriate Submission Grid – Master ("Attachment A") and Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment ("Attachment B"). The Policy undergoes routine review and is updated as necessary to ensure that the Policy and its attachments reflect the latest applicable reporting requirements. This policy was last reviewed by the Board of Directors in December 2020.

Discussion
Following the most recent review cycle, staff identified modifications needed to provide additional clarity and consistency in the Policy's overall language and to reflect changes in operational procedures. Current revisions include:
1) Non-substantive formatting and syntactical updates;
2) Revised Health Network applicability indicators to specify whether the report applies to all Health Networks, Kaiser, and/or Vision Service Plan (VSP);
3) Updated report naming conventions to reflect the change in oversight responsibility from CalOptima's Audit & Oversight Department to other internal departments; and
4) Added reports related to delegated activities.

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Staff recommends that the Board approve the following modifications to Policy HH.2003: Health Network and Delegated Entity Reporting in order to provide additional clarity and consistency regarding reporting requirements for CalOptima's Health Networks and other Delegated Entities. The changes will further support Health Networks and other Delegated Entities in identifying and submitting applicable reports, thereby ensuring compliance with CalOptima requirements.

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

Policy Section	Proposed Change	Rationale	Impact
V. References, Page 4	Removing the "Standard Reporting Requirements Matrix" reference from the policy.	To remove redundant policy references.	No impact to CalOptima or Health Networks, as this is an existing process.
Attachment A, Pages 2 and 6. Attachment B, Pages 11 and 34.	Adding the following reports to the policy. • Case Management Files • 274 Provider Directory – Kaiser	To comply with monitoring requirements outlined in the following: **Case Management Files:** DHCS Contract, APL 17-004, NCQA (PHM5, PHM7). **274 Provider Directory – Kaiser:** DHCS Contract, NCQA (MED14B-D).	Health Networks to ensure these reports are submitted according to the specified reporting requirements, report template, and submission guidelines.

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Policy Section	Proposed Change	Rationale	Impact
Attachment A, Page 7. Attachment B, Pages 35-36.	Adding the following reports to the policy for all Health Networks. • Provider Termination Quarterly Report • UM Retrospective Appeal Universe • Medi-Cal Continuity of Care (COC)	To comply with monitoring requirements outlined in the following: **Provider Termination Quarterly Report:** NCQA (MED1H). **UM Retrospective Appeal Universe:** Health Network Contract. **Medi-Cal COC:** DHCS Contract	Health Networks to ensure these reports are submitted according to the specified reporting requirements, report template, and submission guidelines. CalOptima to ensure Health Networks have all applicable requirements and assist with implementation efforts.
Attachment A, Page 7. Attachment B, Page 36.	Adding the following reports to the policy, specific to Kaiser. • Semi-Annual Site Visit Report - Kaiser • Kaiser Pharmacy Monitoring Report	To comply with monitoring requirements outlined in the following: **Semi-Annual Site Visit Report - Kaiser:** APL 20-006, NCQA (MED3B, MED5B). **Kaiser Pharmacy Monitoring Report:** NCQA (ME 5A-5D).	Kaiser to implement the new reports according to the specified reporting requirements, report template, and submission guidelines. CalOptima to ensure Health Networks have all applicable requirements and assist with implementation efforts.

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Attachment A, Page 1.	Updating the report file name for the following reports to reflect change in the responsible monitoring and oversight department. • Claims XML Universe • Claims Universe Case Files • Credentialing Monthly Universe • Credentialing Universe Monthly Case Files • Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect) • NOMNC Files (OneCare & OneCare Connect) • Provider Dispute Resolution (PDR) XML Universe • PDR Universe Case Files • Provider Directory Universe Case Files • Utilization Management (UM) XML Universe	Monitoring and oversight of Health Network claims, credentialing, provider directory, and utilization management activity is transitioning from CalOptima's Audit & Oversight department to other internal departments. The file names are being updated to ensure reports are routed correctly to the new monitoring and oversight department.	Health Networks to update necessary reporting processes to ensure this report is submitted with the new file name.

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Policy Section	Proposed Change	Rationale	Impact
	• UM Universe Case Files		
Attachment A, Page 2. Attachment B, Page 11.	Updating the description for the following report. • Case Management Log	To reflect the current process for conducting monthly Case Management file selections.	No impact to CalOptima or Health Networks, as this is an existing process.
Attachment A, Page 2. Attachment B, Page 12.	Updating the due date for the following report from the 5th day after the end of the quarter to the 2nd day after the end of the quarter. • Enhanced Monitoring Report Whole Child Model (WCM)	To ensure adequate time for receipt and validation of Health Network reports.	Health Networks to update necessary reporting processes to ensure this report is submitted by the new monthly due date.
Attachment A, Pages 2 and 3. Attachment B, Pages 14-16.	Updating the Report Requirement Indicator for the following reports to include Kaiser. • Implementation Audit (Seniors and Persons with Disabilities/SPD) • Interdisciplinary Care Team (ICT) Bundle (Medi-Cal) • Pediatric ICT Bundle (Medi-Cal)	To comply with Model of Care (MOC) reporting and monitoring requirements outlined in APL 17-012 and APL 18-023.	Kaiser to implement the new reports according to the specified reporting requirements, report template, and submission guidelines. CalOptima to ensure Health Networks have all applicable requirements and assist with implementation efforts.

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Policy Section	Proposed Change	Rationale	Impact
Attachment A, Page 4. Attachment B, Page 20.	Updating the Report Requirement Indicator for the following reports to include Kaiser. • Customer Service Call Log Universe	To comply with monitoring requirements outlined in NCQA MED12D.	Kaiser to implement the new reports according to the specified reporting requirements, report template, and submission guidelines. CalOptima to ensure Health Networks have all applicable requirements and assist with implementation efforts.
Attachment A, Page6. Attachment B, Page 29-30.	Updating the Report Name and the Report Indicator for the following reports to remove VSP from this reporting requirement. • Quality Improvement (QI) Evaluation (Previous Year) – Kaiser • QI Program – Kaiser • QI Work Plan – Kaiser • QI Work Plan Current Year (Initial) - Kaiser • Report of Findings and Actions Taken as a Result of QI Activities - Kaiser	To provide clarity, as VSP is not delegated for Quality Improvement (QI) and is not required to submit such reports. The Delegation Agreement will be updated to reflect the fact that VSP is not delegated for QI.	VSP to stop submitting such QI reports.

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Fiscal Impact
The recommended action to approve revisions to CalOptima Policy HH.2003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, and in the proposed FY 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation
Updates to Policy HH.2003: Health Network and Delegated Entity Reporting will ensure verbiage is consistent throughout the Policy and reflects the applicability of CalOptima reporting requirements for all Health Networks and other Delegated Entities.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Policy HH.2003: Health Network and Delegated Entity Reporting (Redlined and Clean versions), which includes:
    - Timely and Appropriate Submission Grid ("Report Grid")
    - Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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Policy:	HH.2003
Title:	**Health Network and Delegated Entity Reporting**
Department:	Network Operations
Section:	Health Network Relations
CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for submission and evaluation of reports that a Health Network or Delegated Entity is required to submit to CalOptima.

II. POLICY

A. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima, as required by CalOptima or as specified in its contract, the Report Binder (including but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated Entities in the Report Binder.

C. The Report Binder shall contain the following:

1. Report Grid;
2. Report Grid Supplement;
3. Report Templates; and
4. Letter Templates.

D. Each responsible CalOptima department shall be accountable for:

1. Identifying required reports;
    a. Reports must list all applicable regulatory, contractual, and policy citations and include all required data elements.
2. Creating and maintaining the Table of Authorities for each report;
3. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

4. Monitoring submission and timeliness of reports;

5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

7. Escalating issues of continued noncompliance to the Office of Compliance.

E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, on an ongoing basis:

a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

b. With the assistance of the Office of Compliance, review the Report Binder to:

i. Update or correct existing reports;

ii. Identify new reports and associated regulatory, contractual, and policy citations to support new reports;

iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

1. The Health Network Relations Department shall, quarterly, and as necessary:
a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements;

i. CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments;

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder (including, but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

a. CalOptima's secure FTP site; or

b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder and CalOptima's policies and procedures;

b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

d. Report continued noncompliance to the Office of Compliance.

4. The Health Network Relations Department, upon receipt of notification from the responsible department of unsuccessful attempts to contact the Health Network or Delegated Entity, shall:

a. Contact the Health Network or Delegated Entity to obtain the missing report(s) and, if necessary, escalate the issue to the Health Network's senior management; and

b. Work with the department and Health Network or Delegated Entity to correct any content, formatting, or submission issues, if applicable.

5. The Office of Compliance, upon receipt of notification from the responsible department of a Health Network or Delegated Entity's continued noncompliance, shall take appropriate action in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~G. Standard Reporting Requirements Matrix~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2016	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/1999	HH.2003	Health Network Reporting	Medi-Cal
Revised	10/01/2002	HH.2003	Health Network Reporting	Medi-Cal
Revised	07/01/2004	HH.2003	Health Network Reporting	Medi-Cal
Revised	01/01/2007	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/2015	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	09/01/2016	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2017	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	11/01/2018	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	05/01/2019	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), Physician Medical Group (PMG), or a Shared Risk Group (SRG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Letter Templates	For the purposes of this policy, regulatory letter templates issued by regulatory agencies to be used by Health Networks and Delegated Entities for member communications, as required by applicable contractual, policy, and regulatory requirements.
Report Template	A blank form of each report also including instructions and file layout and/or data dictionary.
Sanction	Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs.
Table of Authorities	For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid.
Timely and Appropriate Submission Binder ("Report Binder")	A soft copy document that identifies all reports required of Health Networks to meet CalOptima's operational and regulatory compliance; contains the Report Grid and Report Templates, as well as a data certification statement.
Timely and Appropriate Submission Grid ("Report Grid")	A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy.
Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")	A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy.

Policy:	HH.2003
Title:	**Health Network and Delegated Entity Reporting**
Department:	Network Operations
Section:	Health Network Relations
CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for submission and evaluation of reports that a Health Network or Delegated Entity is required to submit to CalOptima.

II. POLICY

A. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima, as required by CalOptima or as specified in its contract, the Report Binder (including but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated Entities in the Report Binder.

C. The Report Binder shall contain the following:

1. Report Grid;
2. Report Grid Supplement;
3. Report Templates; and
4. Letter Templates.

D. Each responsible CalOptima department shall be accountable for:

1. Identifying required reports;
    a. Reports must list all applicable regulatory, contractual, and policy citations and include all required data elements.
2. Creating and maintaining the Table of Authorities for each report;
3. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

4. Monitoring submission and timeliness of reports;

5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

7. Escalating issues of continued noncompliance to the Office of Compliance.

E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, on an ongoing basis:

a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

b. With the assistance of the Office of Compliance, review the Report Binder to:

i. Update or correct existing reports;

ii. Identify new reports and associated regulatory, contractual, and policy citations to support new reports;

iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

1. The Health Network Relations Department shall, quarterly, and as necessary:
a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements;

i. CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments;

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder (including, but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

a. CalOptima's secure FTP site; or

b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder and CalOptima's policies and procedures;

b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

d. Report continued noncompliance to the Office of Compliance.

4. The Health Network Relations Department, upon receipt of notification from the responsible department of unsuccessful attempts to contact the Health Network or Delegated Entity, shall:

a. Contact the Health Network or Delegated Entity to obtain the missing report(s) and, if necessary, escalate the issue to the Health Network's senior management; and

b. Work with the department and Health Network or Delegated Entity to correct any content, formatting, or submission issues, if applicable.

5. The Office of Compliance, upon receipt of notification from the responsible department of a Health Network or Delegated Entity's continued noncompliance, shall take appropriate action in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2016	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/1999	HH.2003	Health Network Reporting	Medi-Cal
Revised	10/01/2002	HH.2003	Health Network Reporting	Medi-Cal
Revised	07/01/2004	HH.2003	Health Network Reporting	Medi-Cal
Revised	01/01/2007	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/2015	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	09/01/2016	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	HH.2003	Health Network Reporting	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
				OneCare OneCare Connect
Revised	11/01/2018	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	05/01/2019	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), Physician Medical Group (PMG), or a Shared Risk Group (SRG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Letter Templates	For the purposes of this policy, regulatory letter templates issued by regulatory agencies to be used by Health Networks and Delegated Entities for member communications, as required by applicable contractual, policy, and regulatory requirements.
Report Template	A blank form of each report also including instructions and file layout and/or data dictionary.
Sanction	Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs.
Table of Authorities	For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid.
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Timely and Appropriate Submission Grid ("Report Grid")	A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy.
Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")	A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy.

CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ ~~FTP FILE PATH FOR TEMPLATE~~ (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Audit and Oversight	**Annually; Per process**	1_AORPT_**HN_CAT**	HN = Health network # CAT = Audit Category	hn_reporting	Zip	x	x	x	x	x	x	x	
Claims XML Universe	Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0.	/users/Documentation Library/XML Version 2.0/Claims	~~Audit and Oversight~~ Claims	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Claims	**Monthly: 10th of every month**	1_~~AORPT~~ **CLMRPT_HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight and~~ Quality Improvement	**Health Networks and Kaiser Monthly: 2nd of every month VSP Quarterly: January 10, April 10, July 10, October 10**	~~2_AORPT~~ 1_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x	x	
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight and~~ Quality Improvement	**Monthly: 10th of every month**	1_~~AORPT~~ QIRPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	x	x	x	x	x	x	x	
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Utilization Management	**Monthly: 2nd of every month**	1_~~AORPT~~ UMRPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word		x	x	x			x	
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Utilization Management	**Monthly: 10th of every month**	1_~~AORPT~~ UMRPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF		x	x	x			x	
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Claims	**Monthly: 2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Claims	**Monthly: 10th of every month**	1_~~AORPT~~ CLMPRT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Provider Relations/PDMS	**Annually, per request**	1_~~AORPT~~HMRPT_**HN**_PD_**QTYYYY**	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF (zip)	x	x	x	x			x	
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1.	/users/Documentation Library/XML Version 2.1/Authorizations	~~Audit and Oversight~~ Utilization Management	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_UM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x		x	
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	~~Audit and Oversight~~ Utilization Management	**Monthly: 10th of every month**	1_~~AORPT~~ UMRPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x		x	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Monthly: 15th of every month**	1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x				x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ ~~FTP FILE PATH FOR TEMPLATE~~ (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report, containing mental health grievances and appeals data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Quarterly; January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	x				x		x	
Case Management Log	Health Networks shall submit monthly Case Management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x		x **[Remove]**	x	x		x	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **1 week after CalOptima request**	Secure email to Case Management.	N/A	N/A	PDF	x			x	x		x	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Weekly; every Tuesday by 10 am for the prior week's activity**	1_WCMMC_**HN_YYYYMMDD**_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, Regulatory Affairs	**Quarterly; ~~5th~~ 2nd day after the end of the quarter**	1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **10th of every month**	**HN**_HHP_Enrollment.csv	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **10th of every month**	**HN**_HHP_ReturnFEL	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **10th of every month**	1_HHPServices_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF		x		x			x	
Implementation Audit (Seniors and Persons with Disabilities (SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inbound	PDF	x			x	x		x	
Organ Transplant - Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly:** **15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_AR_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	HN#_CIN_HHP_MMDDYYYY	HN=Health network reporting #,CIN-, MM=2 digit month, DD-2 digit day, YYYY=4 digit year (MMDDYYY=date ICP/HAP completed)	HN#HNname/MediCal/HHP MOC/Inbound	PDF	x			x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OneCare/RevisedMOC/Inbound	PDF		x		x			x	
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	x			x	x		x	
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OCC/RevisedMOC/Inbound	Pipe delimited text file			x	x			x	
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file		x		x			x	
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**275**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	WCM Revised MOC/Inbound	Pipe delimited text file	x			x			x	
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Pipe delimited text File	x	x	x	x			x	

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CalOptima
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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~/~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~/ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, GARS, Utilization Management	**Monthly:** **15th of every month** **First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter**	1_WCMMC_04_**YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x				x		x	
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management and Population Health Management	**Annually:** **February 15**	2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, Utilization Management	**Monthly:** **15th of every month** **First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter**	1_WCMMC_**HN_YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x			x	
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly:** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	x			x	x		x	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly:** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF			x	x			x	
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly:** **3rd business day of every month**	1_MCPPR_XX_YYYYPP_SS	HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year	hn_reporting	Text File	x			x	x		x	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 7, April 7, July 7, October 7**	MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY**	HN = Health network # QQ = 2 digit quarter (Q1, etc) YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly:** **15th of every month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS_2019	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
DHCS NMT/NEMT Report - Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service, GARS	**Monthly:** **27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15** **Final: Annual submission of all 12 months due June 30**	1_FINRPT_**HN_SemiAnnualYYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	x		x	x			x	

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Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ ~~FTP FILE PATH FOR TEMPLATE~~ (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	x	x	x	x			x	
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_HMO04_QQYYYY_VOL	QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS, Customer Service, Long Term Services and Supports	**Quarterly: January 23, April 23, July 23, October 23**	3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS	QT = 2 digit Quarter # YYYY = 4 digit year	Incoming	Text File	x				x		x	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly: 25th of every month**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	x			x	x	x	x	
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Quarterly: January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Bi-monthly: 10th and 25th of every month**	**HN**204**JJJ**	HN = Health network reporting # JJJ = Julian Date	hn_reporting	Excel	x			x			x	
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/IS	IS	**Monthly; 15th of every month**	CalOptima_KSR_PRD_Supplementals_[yyyymm].txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	x				x		x	
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly: 15th of every month**	VSP_Medicaid_CA_Orange_County_Provider_Listing_**YYYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day		Excel	x					x	x	
Health Education Calendar - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually: January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Health Education Individual Encounters - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Health Education Other Encounters - Kaiser	Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Monthly: 15th of every month**	1_DMRPT_04_**MMYYYY**_PSS_Services	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Analytics	Quality Analytics	**Annually: February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	x				x		x	

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Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Quality Improvement (QI) Evaluation (Previous Year) - Kaiser~~, VSP~~	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x	~~x~~ [REMOVE]	x	
QI Program - Kaiser~~, VSP~~	Kaiser shall develop an annual QI report and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x	~~x~~ [REMOVE]	x	
QI Work Plan - Kaiser~~, VSP~~	Kaiser shall report progress towards QI program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x	~~x~~ [REMOVE]	x	
QI Work Plan Current Year (Initial) - Kaiser~~, VSP~~	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15 (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x	~~x~~ [REMOVE]	x	
Report of Findings and Actions Taken as a Result of QI Activities - Kaiser~~, VSP~~	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Quarterly**	1_QIRPT_HN_QTYYYY_QI Findings	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF	x				x	~~x~~ [REMOVE]	x	
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). Unused authorization reporting shall include the claims status for each referral authorized during the measurement period.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021**	1_~~QIRPT~~ UMRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly: 15th of the month after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Work Plan ~~(ICE)~~	Health Networks shall report progress towards UM program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Semi-Annually: February 15 and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15 (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly: January 25, April 25, July 25, October 25**	1_UMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 15th of every month**	Kaiser_ClaimDetail_MMDDYY	DD = 2 digit day MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly: 10th of every month**	2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x		x
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly: 10th of every month**	1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x			x	x			x
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Monthly: 15th of every month**	WCM04RXCCYYMMDD	MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation.	https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx	Office of Compliance	**Initial upon contracting; Annually thereafter**	FDR Compliance Attestation	N/A	email to compliance@caloptima.org	PDF	x	x	x	x	x	x	x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "~~FTP File Path for Template~~ ~~Link to Template~~ (Health Network)" for required reporting elements)	~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC, OC, DB	hn_reporting	Excel	x	x	x	x	x	x	x	
274 Provider Directory - Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly** **2nd of every month**	**HN**274**YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	274/inbound/	Text File	x				x		x	
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Provider Relations/PDMS	**Monthly: 15th of the month with all manadatory fields populated** **Quarterly:** **10th of the month following the end of each quarter**	1_HNRPT_TermSubmission_**QQYYYY_HN**	QQ = 2 digit caledar quarter (e.g., 01 = Quarter 1, JAN-MAR) HN = Health Network YYYY= 4 digit year reporting #	hn_reporting	Excel	x			x	x		x	
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly:** **10th of the month following the end of each quarter**	1_GARSRPT_Retro Auth Appeals_**HN_YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x	x	x	x	x		x	
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually:** **February 15 and August 15**	1_QIRPT_04_**MMDDYYYY**_FSR Semi Annual Report	YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x				x		x	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Semi-Annually:** **April 1 and October 1**	Kaiser_Pharmacy_Monitoring_Report_**MMYYYY**.pdf	YYYY= 4 digit year MM = 2 digit month	Email to CalOptima Pharmacy Management Department	PDF	x				x		x	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Monthly:** **1st Tuesday of each month**	1_COCMC_**HN_YYYYMMDD**.xls	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Manged_HN_Reporting/COCMC/Inbound	Excel	x			x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Audit and Oversight	**Annually;** **Per process**	1_AORPT_**HN_CAT**	HN = Health network # CAT = Audit Category	hn_reporting	Zip	x	x	x	x	x	x	x	
Claims XML Universe	Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0.	/users/Documentation Library/XML Version 2.0/Claims	Claims	**Monthly:** **2nd of every month**	2_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly:** **10th of every month**	1_CLMRPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Quality Improvement	**Health Networks and Kaiser Monthly:** **2nd of every month** **VSP** **Quarterly:** **January 10, April 10, July 10, October 10**	1_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x	x	
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Quality Improvement	**Monthly:** **10th of every month**	1_QIRPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	x	x	x	x	x	x	x	
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly:** **2nd of every month**	1_UMRPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word		x	x	x			x	
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly:** **10th of every month**	1_UMRPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF		x	x	x			x	
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly:** **2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly:** **10th of every month**	1_CLMPRT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Provider Relations/PDMS	**Annually, per request**	1_HMRPT_**HN**_PD_**QTYYYY**	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF (zip)	x	x	x	x			x	
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1.	/users/Documentation Library/XML Version 2.1/Authorizations	Utilization Management	**Monthly:** **2nd of every month**	2_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x		x	
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly:** **10th of every month**	1_UMRPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Monthly: 15th of every month**	1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x				x		x	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report, containing mental health grievances and appeals data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Quarterly; January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	x				x		x	
Case Management Log	Health Networks shall submit monthly Case Management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 1 week after CalOptima request**	Secure email to Case Management.	N/A	N/A	PDF	x			x	x		x	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Weekly; every Tuesday by 10 am for the prior week's activity**	1_WCMMC_**HN_YYYYMMDD**_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, Regulatory Affairs	**Quarterly; 2nd day after the end of the quarter**	1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	**HN**_HHP_Enrollment.csv	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	**HN**_HHP_ReturnFEL	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	1_HHPServices_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF		x		x			x	
Implementation Audit (Seniors and Persons with Disabilities (SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inbound	PDF	x			x	x		x	
Organ Transplant - Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_AR_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	HN#_CIN_HHP_MMDDYYYY	HN=Health network reporting #,CIN-, MM=2 digit month, DD-2 digit day, YYYY=4 digit year (MMDDYYY=date ICP/HAP completed)	HN#HNname/MediCal/HHP MOC/Inbound	PDF	x			x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN_**ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN_**SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBER CIN_**ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OneCare/RevisedMOC/Inbound	PDF		x		x			x	
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN_**LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN_**SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN271CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	x			x	x		x	
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OCC/RevisedMOC/Inbound	Pipe delimited text file			x	x			x	
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file		x		x			x	
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**275**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	WCM Revised MOC/Inbound	Pipe delimited text file	x			x			x	
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Pipe delimited text File	x	x	x	x			x	
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN_**WCM_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, GARS, Utilization Management	**Monthly: 15th of every month** **First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter**	1_WCMMC_04_**YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x				x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management and Population Health Management	**Annually: February 15**	2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management, Utilization Management	**Monthly: 15th of every month** **First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter**	1_WCMMC_**HN_YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x			x	
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	x			x	x		x	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF			x	x			x	
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 3rd business day of every month**	1_MCPPR_XX_YYYYPP_SS	HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year	hn_reporting	Text File	x			x	x		x	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 7, April 7, July 7, October 7**	MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY**	HN = Health network # QQ = 2 digit quarter (Q1, etc) YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly: 15th of every month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS_2019	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
DHCS NMT/NEMT Report - Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service, GARS	**Monthly: 27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15** **Final: Annual submission of all 12 months due June 30**	1_FINRPT_**HN_SemiAnnualYYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	x		x	x			x	
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	x	x	x	x			x	
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_HMO04_QQYYYY_VOL	QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS, Customer Service, Long Term Services and Supports	**Quarterly: January 23, April 23, July 23, October 23**	3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS	QT = 2 digit Quarter # YYYY = 4 digit year	Incoming	Text File	x				x		x	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly: 25th of every month**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	x			x	x	x	x	
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Quarterly: January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Bi-monthly: 10th and 25th of every month**	**HN**204**JJJ**	HN = Health network reporting # JJJ = Julian Date	hn_reporting	Excel	x			x			x	
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/IS	IS	**Monthly; 15th of every month**	CalOptima_KSR_PRD_Supplementals_[yyyymm].txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	x				x		x	
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly: 15th of every month**	VSP_Medicaid_CA_Orange_County_Provider_Listing_**YYYYMMDD**	HN = Health network reporting # CCYY = 4 digit year MM = 2 digit month DD = 2 digit day		Excel	x					x	x	
Health Education Calendar - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually: January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Health Education Individual Encounters - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Health Education Other Encounters - Kaiser	Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Monthly: 15th of every month**	1_DMRPT_04_**MMYYYY**_PSS_Services	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Analytics	Quality Analytics	**Annually: February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	x				x		x	
Quality Improvement (QI) Evaluation (Previous Year) - Kaiser	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
QI Program - Kaiser	Kaiser shall develop an annual QI report and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
QI Work Plan - Kaiser	Kaiser shall report progress towards QI program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
QI Work Plan Current Year (Initial) - Kaiser	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15 (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Report of Findings and Actions Taken as a Result of QI Activities - Kaiser	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Quarterly**	1_QIRPT_HN_QTYYYY_QI Findings	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF	x				x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). Unused authorization reporting shall include the claims status for each referral authorized during the measurement period.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **Q3 2020 - February 15, 2021** **Q4 2020 - May 15, 2021** **Q1 2021 - August 15, 2021** **Q2 2021 - November 15, 2021**	1_UMRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **15th of the month after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Work Plan	Health Networks shall report progress towards UM program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Semi-Annually:** **February 15 and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15 (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **January 25, April 25, July 25, October 25**	1_UMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly:** **15th of every month**	Kaiser_ClaimDetail_MMDDYY	DD = 2 digit day MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly:** **10th of every month**	2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x		x
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly:** **10th of every month**	1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x			x	x			x
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Monthly:** **15th of every month**	WCM04RXCCYYMMDD	MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation.	https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx	Office of Compliance	**Initial upon contracting;** **Annually thereafter**	FDR Compliance Attestation	N/A	email to compliance@caloptima.org	PDF	x	x	x	x	x	x	x	
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC, OC, DB	hn_reporting	Excel	x	x	x	x	x	x	x	
274 Provider Directory - Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly** **2nd of every month**	**HN**274**YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	274/inbound/	Text File	x				x		x	
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Provider Relations/PDMS	**Monthly: 15th of the month with all manadatory fields populated** **Quarterly:** **10th of the month following the end of each quarter**	1_HNRPT_TermSubmission_**QQYYYY_HN**	QQ = 2 digit caledar quarter (e.g., 01 = Quarter 1, JAN-MAR) HN = Health Network YYYY= 4 digit year reporting #	hn_reporting	Excel	x			x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: 10th of the month following the end of each quarter**	1_GARSRPT_Retro Auth Appeals_**HN_YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x	x	x	x	x		x	
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_04_**MMDDYYYY**_FSR Semi Annual Report	YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x				x		x	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Semi-Annually: April 1 and October 1**	Kaiser_Pharmacy_Monitoring_Report_**MMYYYY**.pdf	YYYY= 4 digit year MM = 2 digit month	Email to CalOptima Pharmacy Management Department	PDF	x				x		x	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Monthly: 1st Tuesday of each month**	1_COCMC_**HN_YYYYMMDD**.xls	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Manged_HN_Reporting/COCMC/Inbound	Excel	x			x	x		x	

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CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable: • Access & Availability • Care Delivery Model • Claims • Compliance • Credentialing • Cultural & Linguistics • Customer Service • Encounters • Information Systems • Mailroom Process • Marketing • Medi-Cal Addendum • Member Grievances & Appeals • Network Management • Provider Network Contracting • Provider Relations • Quality Improvement • Sub-Contractual • Translation Services • Utilization Management • Whole Child Model	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13 Medicare Managed Care Manual, Chapter 11, Section 110.2 APL 17-004: Sub-Contractual Relationships and Delegation	Annually: per process	X	X	X	X	X	X
Claims XML Universe	Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0. The report includes the following: • Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process) • CalOptima Line of Business (LOB) • Claim number, form type, bill type in UB04, admission code, place of service name and code • Authorization number • Was claim adjusted and clean • Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10	Monthly: 2nd of every month	X	X	X	X	X	X

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Beneficiary name, Client Identification Number (CIN), threshold language • Requestor type, receipt date and time • Date and time of additional information requested (AIR) • Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status • Rendering provider name, NPI, Tax ID, specialty, contracted status • Medical necessity denials • Date and time claim received, loaded in system, decision made, claim redirected • Payment information method, number, print date and time, transfer date and time • Mail date and time of written notification to member and provider • Decision maker name, title and credentials • International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting • Date of service • Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount • Paid revenue code, description, and CPT/HCPC • Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description • Paid reason for CPT/HCPC change • Decision type and decision denial reason	DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual Chapter 11, Section 110.2 Title 42, Code of Federal Regulations (CFR), Sections: 422.520 (a) 447.45 (d)							

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Paid Claims:</u> • Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date) • Authorization, if applicable • Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable • Proof of check clearing (bank statements or copy of cancelled check) <u>Denied/Contested Claims:</u> • Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date) • Eligibility print screen if contested/denied for eligibility • System notes pertaining to claim • If applicable, denial letters for member liability denials and any supporting documents used to determine the denial • RA/EOB with interest, if applicable <u>Adjustments:</u> • Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt) • Original RA/EOB showing payment or denial • Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.) • Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.) • All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development • RA/EOB with applicable interest • Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10 DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.520 (a) 447.45 (d)	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Health Network name, reporting month and year • Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report • Data ID (IC/RC/TM) • CalOptima program (Medi-Cal, OneCare, OneCare Connect) • Individual practitioner name, license number and type • Contract type and primary contracted specialty • Current and previous credentialing decision dates • Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date • Current facility site review date • Current, signed attestation date • Termination date and reasons for termination • Date Change Termination (CT) form was submitted	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2	<u>Health Networks and Kaiser</u> Monthly: 2nd of every month <u>VSP</u> Quarterly: January 10, April 10, July 10, October 10	X	X	X	X	X	X
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Initial Credentialing</u> • Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter • File checklist • Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Work history, and education and training verification • Board certification verification, as applicable	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities	Monthly: 10th of every month	X	X	X	X	X	X

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners <u>Recredentialing</u> • Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • File checklist • Performance monitoring documentation • Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Board certification verification, as applicable • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners	CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2							
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. The report includes the following: • Member identifier, medical record number, and facility service type • Date of termination request/notice and date of actual termination	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2	Monthly: 2nd of every month		X	X	X		

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt • Date of discharge	Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)							
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. NOMNC files include the following: • Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services • Date of termination request • Date of actual termination (including date, time and name of provider making the request) • Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services) • Member/member's representative notified of appeal rights • Date of termination request/notification signed by the member/member's representative • Copy of signed NONMC letter • Date of discharge If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required: • Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice) • Proof of letter mailed on same date of call made to member's representative • If provider is unable to reach member's representative by phone, provide proof of the following: o Certified mail receipt with return receipt request o Date someone at the representative's address signs or refuses to sign the letter o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)	Monthly: 10th of every month		X	X	X		
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0. The report includes the following: • Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect) • Unique ID number used to track authorization request • Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR • Check number used to pay overturned PDR request, and date and time check was mailed • Date and time the written notification was provided to the provider • Name and title of the decision maker of the PDR request	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2	Monthly: 2nd of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received • Billing provider's name, NPI number, tax ID number, specialty, and whether contracted • Claim number of the original claim being appealed, and decision date and time of the original claim being appealed • Member's name, CIN, and preferred language • ICD type and diagnosis code • Start date and end date of services rendered • Billed revenue code, CPT/HCPC code, and modifier • Billed units and billed amount • Paid amount (excluding interest), withhold amount, and paid interest amount • Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason • Adjustment code and description	Health and Safety Code (HSC), Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, California Code of Regulations (CCR), Section 1300.71.38: (b) (c) (d)							
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: • Copy of original claim, and received date (if electronic claim, a print screen showing received date) • Original RA/EOB showing payment or denial • Provider dispute request along with pertinent documents submitted, and date received • All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development • Acknowledgement letter, and resolution letter sent to provider • EOB showing payment with applicable interest, if original decision of payment denial is overturned • Proof of check clearing (bank statements or copy of cancelled check) if payment is issued	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 HSC, Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, CCR, Section 1300.71.38: (b) (c) (d)	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results. The Provider Directory file review is based on a signed and dated provider attestation that includes the following: • Provider name, California license number, and gender • Address (office locations), office days and hours, day phone number, and after-hours phone number • Administrative email address, or office fax number (if no administrative email available) • Languages spoken by provider and staff • Primary specialty (i.e. dermatology, internal medicate, etc.) • Accepting new patients (i.e., open or closed panel), and age restrictions • Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital) • Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP) • Programs (i.e. Medi-Cal, OneCare, OneCare Connect) • Provider type in this network (i.e. Primary Care Provider, Specialist) • Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number • Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment." • Designated space for printed name, signature and date for the provider office manager or equivalent staff	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Health Network Contract, Section 7.10 CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.17.5.11 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4 HSC, Section 1367.27 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Section 438.10 (h)	Annually, per request	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1. The report includes the following: • Version, as of date, entry identification (ID), and line of business (LOB) for this authorization • ID number used to track the authorization request (AR), and type of AR • Whether authorization is for Part B or physician administered drugs and/or administration • Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist • Method AR was received, and authorization number related to AR • CMS place of service code and name • Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network) • Member name, CIN, and preferred language • AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator) • Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB) • Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received • Requesting provider/group/facility name, NPI, tax ID number, and whether contracted • Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit) • Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date • Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe • If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe • If a request to expedite was made after the original request, identify requestor of subsequent request to expedite • Whether a timeframe extension was taken • Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member • The method used to initially notify the requesting provider of the decision of authorization request • Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream • Whether the review was completed by a physician or other appropriate health care professional • Name, job title, and credentials of the decision maker of the AR • Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description • Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units • Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units • Determination of the requested service • Reason for the denial or modification of the requested service	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1) Medicare Part C Reporting Requirements, Section VI	Monthly: 2nd of every month	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. UM case files include the following documentation: <u>Medi-Cal</u> • Approval file checklist includes all medical records attached to file and transaction log • Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log • Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log <u>OneCare</u> • Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file and transaction log <u>OneCare Connect</u> • Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1)	Monthly: 10th of every month	X	X	X	X	X	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. The report includes the following: • Plan code, name, county and reporting period • Number of CDE referrals • Number of referrals determined appropriate for CDE • Number of CDE completed • Number of CDE appointments scheduled within and outside timely access • Number of CDE not scheduled but offered appointment • Number of CDE with appointment not yet scheduled • Comments	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Monthly: 15th of each month	X				X	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data. The report includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Quarterly: January 20, April 20, July 20, October 20	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Plan code, name, county, reporting quarter and total number of members • Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code • Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description • Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period • Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for • Average number of days taken to deny requests • Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description • Number of COC requests in process and comments								
Case Management Log	Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Member name, CIN, date of birth, and program • Diagnosis and ICD-10 code (qualifying member for case management) • Referral/data source to case management, date opened, and date closed • Case management level, status change reason, and complex case trigger • Additional programs to which member has been referred • Special program to which member is enrolled, or any special needs of member	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 15th of every month	X		~~X~~	X	X	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Identification date for Complex Case Management • Nursing Assessment • Care Notes • Care Plan	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 1 week after CalOptima request	X			X	X	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. The report includes the following: • Requestor type, date of request, and request type	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6	Weekly: Every Tuesday by 10 am for the prior week's activity	X			X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Member name and CIN • COC begin processing date and date of decision • COC completion date (including member notification) and COC expiration date • Requested provider NPI and provider type • Decision outcome, denial reason, and explanation of other reasons • Next steps taken for incomplete requests	Attachment 11, Provision 10							
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. The report includes the following: Health Networks (including Kaiser): • Describe any challenges with care coordination and Health Network's role in overcoming barriers • Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions • For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes Kaiser Only: • Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP • Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Quarterly: ~~5th~~ 2nd day after the end of the quarter	X			X	X	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. The report includes the following: • Member name, CIN, and date of birth • Whether HHP enrolled member was externally referred • HHP disenrollment date and reason • Whether member is homeless/at risk for homelessness, or received housing services during reporting period • Whether member was homeless at any point during enrollment in HHP • Whether member is no longer homeless as of the last day of reporting period • File create date	DHCS HHP Program Guide CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. The Health Network response file includes the following: • Excluded because not eligible-well managed: Y/N • Excluded because declined to participate: Y/N • Excluded because of unsuccessful engagement: Y/N • Excluded because of duplicative program: Y/N • Excluded because of unsafe behavior or environment: Y/N • Excluded because not enrolled in Medi-Cal at MCP: Y/N	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management	Monthly: 10th of every month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Enrollment date (if applicable)	CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility							
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. The report includes the following: • Claim line ID • Health Network ID, claim number, claim line number • Member name and CIN • Date of service and service provided • Claim or encounter received date • Whether an adjustment, and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT code and modifier, and primary diagnosis • Units billed and provider billed amount • Paid amount, and adjustment code • Fee-for-service or capitated claim • Check or EFT transaction number • Optional user defined fields	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements, Section A. Care Plans Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA1.5 CA1.6 CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements	Ongoing, per process			X	X		
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following:	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes								
Implementation Audit (Seniors and Persons with Disabilities (~~or~~ SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Organ Transplant – Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process. The report includes the following: • Member name, CIN, and date of birth • Transplant related diagnosis and transplant type • DHCS-approved transplant center where member will be transplanted • Date the Health Network notified CalOptima of member's potential transplant status • Current transplant phase and the date the phase began • Date member is listed for transplant at DHCS-approved transplant center • Date member was last contacted regarding case management/coordination care issues • Date the transplant case is closed and reason for case closure • Case manager name • Additional comments to clarify report	APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions Cal MediConnect 3-Way Contract, Section 2.2.4	Monthly: 15th of every month	X				X	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. The report includes the following: • Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination. • WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Section 6 Attachment 11, Section 10	Ongoing, per process	X			X	X	
Individual Care Plan/Health Action Plan	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.	Medi-Cal Health Homes Program Guide APL 18-012: Health Homes Program Requirements	Ongoing, per process	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
(ICP/HAP) bundle	The report includes the following: • Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills. • Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals. • Clinical assessments/case management notes								
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA 1.1 - CA 1.5 OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 Medicare Managed Care Manual, Chapter 5, Sections: 20.2.1 2.C and D DPL 15-001: ICP and ICT Requirements	Ongoing, per process			X	X		
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP								
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Final ICP that includes assessments, interventions, and goals set by the facility • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2	Ongoing, per process			X	X		
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. The report includes the following: • ICT notes/minutes, participants invited according to member's needs, and ICT attendees • Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Copy of Care Planning Letter sent to Member with date mailed and preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2	Monthly: 6th of every month	X			X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1	Monthly: 6th of every month			X	X		
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month		X		X		
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Monthly: 6th of every month	X			X		
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Staff name, number (unique for each individual PCC or CC, phone number, and email • For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments • Model of Care (MOC) training received • PCC training received and PCC staffing ratio met	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month	X	X	X	X		

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans • Type of licensed staff or non-licensed CC staff • Attestation from Manager/Director (name and title) to report information								
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Ongoing, per process	X			X	X	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date • Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider • Number of other WCM grievances and summary of such grievances • Number of WCM appeals and summary of appeals	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4 Attachment 11, Provision 10	Monthly: 15th of every month	X				X	
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review. The report includes the following: • Quantitative results for relevant clinical, cost/utilization and experience measures • Comparison of results with a benchmark	NCQA Standards, Population Health Management, PHM7	Annually: February 15th	X				X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11 Provision 10	Monthly: 15th of every month	X			X		
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure codes(s) and description of services rendered • Amount subcontractor or out-of-plan Provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL) APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements Cal MediConnect 3-Way Contract, Section 5.1.13.1 DHCS Medi-Cal Contract, Exhibit E, Attachment 2	Monthly: 30th of every month	X			X	X	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure code(s) and description of services rendered • Amount subcontractor or out-of-plan provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability Title 42, CFR, Sections: 405.378 411.24 422.108 423.462 CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights" Cal MediConnect 3-Way Contract, Section 5.1.13	Monthly: 30th of every month			X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima. The report includes the following: • Project type (Third Part Liability "TPL") • Name of Provider billing the claim, and provider tax ID number • Claim type (What kind of claim was submitted, Facility, Professional, etc.) • Member name, date of birth, ID number, and social security number • Transaction control number (claim number) • Begin date and end date of service • Coordinated care organization bill amount (amount billed to TPL/Provider) • Coordinated care organization paid amount (amount paid to the Provider) • Bill date (date the claim was billed to the TPL) • Remit amount (amount recovered from the TPL) • Claim date of remit (date the claim was paid or denied by TPL) • Check number related to remit amount • Other insurance carrier name (name of the TPL that was billed) • Claim status (disposition of the claim, paid, denied, open, etc.) • Denial reason (the reason the claim was denied by the TPL)	APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage	Monthly: 3rd business day of every month	X			X	X	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. The report includes the following: • File ID number, and line of business • Member name and cardholder ID (assigned by HN to identify member) • Date and time the call was received • Category of the call and detailed description of the call • Detailed description of the outcome/resolution of the call • Date and time the call was resolved • Customer Service Representative name who handled the call • Member's language	DHCS Medi-Cal Contract, Exhibit A: Attachment 13, Provision 2 Attachment 14, Provision 1 Attachment 14, Provision 2 Health and Safety Code (HSC), Section 1368(a)(1) Title 28, CCR, Section 1300.68(a) Cal MediConnect 3-Way Contract, Section 2.14 Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance NCQA Element MED12D: Providing Information to Medicaid Members in the Practitioner Directory (Kaiser)	Quarterly: January 7, April 7, July 7, October 7	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review. The report includes the following: • Total number of calls, average speed of answer, and average length of call in seconds • Service levels (percentage of incoming calls answered within 30 seconds) • Average speed to answer member services telephone calls with a live voice • Abandonment rate (percentage of incoming calls disconnected) • Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services) • Number of calls by language	CalOptima Health Network Contract, Sections: 3.5 7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3	Monthly; 15th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. The report includes the following: • Requests for interpreter services by language (number of requests received, and number of requests fulfilled) • Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff • Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff • Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted)	DHCS Medi-Cal Contract, Exhibit A, Attachment 6 Cal MediConnect 3-Way Contract, Section 2.11.1.2.2	Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS NMT/NEMT Report – Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT denials • Number of NMT and NEMT calls • Number of NMT and NEMT grievances, and grievance reasons • NMT/NEMT reporting comments	APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services DHCS Medi-Cal Contract, Exhibit A, Attachment 10 Welfare and Institutions Code, Section 14132	Monthly: 27th of every month	X				X	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). Audited financial statements include the following: • Letters to management, and incurred but not reported (IBNR) documentation • Consolidated corporate audited financial statements (if Health Network is part of a larger entity)	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures								
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. The IBNR documentation includes the following: • Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims • Supporting documentation for the IBNR calculation	CalOptima Policy FF.3001 Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR. MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	CalOptima Policy FF.3001: Financial Reporting	Interim: January - June due August 15 Interim: January - December due February 15 Final: Annual submission of all 12 months due June 30	X		X	X		
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3.	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 150 days after the fiscal year ends Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization. Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures.	CalOptima Policy FF.3001: Financial Reporting	Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Year, quarter, plan code, member CIN • Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3 APL 14-013: Grievance Report Template	Quarterly: January 23, April 23, July 23, October 23	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• For the other category, grievance type(s) must be defined by HN • Whether grievance was resolved (in favor of member or HN) or unresolved	APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments							
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other • Total of all grievance types	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3	Quarterly: January 23, April 23, July 23, October 23	X				X	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, reporting quarter • Number of requests for CBAS, and number of CBAS Providers • Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services • Average number of days between CBAS request and notice of eligibility • Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center • Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances • Number of CBAS appeals approved, denied, and withdrawn • Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS • Number of CBAS complaint calls from member and from provider • Explanations and summary of CBAS complaints • CBAS reporting comments	CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6	Quarterly: January 23, April 23, July 23, October 23	X				X	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful. The most current template Data Certification Statement in the Report Binder shall be utilized and include the following: • Health Network name, certification month and year • Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer) • Signature date, job title, and Health Network department.	APL 17-005: Certification of Document and Data Submissions DHCS Medi-Cal Contract, Exhibit E, Attachment 2 CalOptima Health Network Contract, Section 7.12	Monthly: 25th of each month	X			X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. The report includes the following: • Program (Medi-Cal, OneCare, OneCare Connect) • Provider name, NPI, and active status date • Date the training started and date the training was completed • Whether signed acknowledgment was received from provider • Comments/explanation of missed deadline(s)	CalOptima Policy EE.1103: Provider Education and Training DHCS Medi-Cal Contract, Exhibit A: Attachment 7, Provisions 5 Attachment 9, Provision 12 APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities Cal MediConnect 3-Way Contract, Section 2.9.11	Quarterly: January 25, April 25, July 25, October 25	X	X	X	X	X	X
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. The report includes the following: • Member site, ID, and suffix • PCP effective date, ID, and suffix • Health Network ID and suffix • Medical center ID and suffix • Staff Vs center indicator • Pay to Tax ID number (Health Network Tax ID) • Pay to Tax ID suffix • PCP reason code • Name of individual provider, group, or clinic	CalOptima Health Network Contract, Sections: 3.12 7.1 7.11 CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4 CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP)	Bi-monthly: 10th and 25th of every month	X			X		
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. The report includes the following: • Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI). • Member name and CIN • Health Care Plan (HCP) code • Month of service • Member enrollment status indicator • Services rendered • Diagnosis date • Delivery date • Number of weeks for Hep-C multiplier • Indicator for correction record • Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret	DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16 Technical Guidance: Consolidated Supplemental Upload Process	Monthly: 15th of every month	X				X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Number of encounters								
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories. The report includes the following: • Practice name, doctor name, and provider specialty • Provider address, phone number, and county name • Non-English languages spoken by provider and/or clinical staff • Provider NPI, license number and type, special experience, and gender • Accepting new patients, and ages seen • Hours of operation from Monday through Sunday	CalOptima VSP Contract, Sections: 1.17 7.1	Monthly: 15th of every month	X					X
Health Education Calendar - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes. The report shall include, at a minimum: • Class or program name • Location • Date and time	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Individual Encounters-Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Other Encounters - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts. The data include the following: • Member CIN • Member DOB • Estimated Delivery Date • Participating in CPSP (Y/N) • Date CPSP Initiated	CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7	Monthly: 15th of every month	X				X	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. The report includes the following: • Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access • Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access • Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services • Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network • Documenting at least one intervention and measure effectiveness of interventions (if applicable)	DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation DHCS Proposed Annual Network Certification Policy Changes NCQA Standards, Network Management: Net 1B – 1D Net 2A – 2C Net 3A – 3C CalOptima Policy GG.1600: Access and Availability Standards CalOptima Policy MA.7007: Access and Availability Title 28, CCR, Sections: 1300.67.2 1300.67.2.1 1300.67.2.2 DHCS Medi-Cal Contract, Exhibit A: Attachment 6 Attachment 9 Cal MediConnect 3-Way Contract, Section 2 Title 42, CFR, Section 438.206-207	Annually: February 15	X				X	
Quality Improvement (QI) Evaluation	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. The evaluation includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4	Annually: February 15	X				X	✘

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
(Previous Year) – Kaiser~~, VSP~~	• A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service • Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices	~~CalOptima VSP Contract, Section 4.2~~ NCQA Standards, Quality Improvement, QI7							
QI Program – Kaiser~~, VSP~~	Kaiser shall develop an annual QI program description and submit to CalOptima for review. The program includes description of the following: • The QI program structure • The behavioral healthcare aspects of the program • Involvement of a designated physician in the QI program • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program • Oversight of QI functions of the organization by the QI Committee • Objectives for serving a culturally and linguistically diverse membership	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 ~~CalOptima VSP Contract, Section 4.2~~ NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	~~X~~
QI Work Plan – Kaiser~~, VSP~~	Kaiser shall report progress towards quality improvement program goals semi-annually. The QI work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 ~~CalOptima VSP Contract, Section 4.2~~ NCQA Standards, Quality Improvement, QI7	Semi-Annually: February 15 and August 15	X				X	~~X~~
QI Work Plan Current Year (Initial) – Kaiser~~, VSP~~	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 ~~CalOptima VSP Contract, Section 4.2~~ NCQA Standards, Quality Improvement, QI7	Annually; February 15 (for new year)	X				X	~~X~~

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Report of Findings and Actions Taken as a Result of QI Activities – Kaiser~~, VSP~~	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities. The report includes the following, at a minimum: • Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions) • An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB)	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 ~~CalOptima VSP Contract, Section 4.2~~ NCQA Standards, Quality Improvement, QI7	Quarterly	X				X	~~X~~
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). The report includes the following: • Member name, Client Identification Number (CIN), and date of birth • Health Network name or number, and PCP name • Authorization tracking/case number • Authorization request date, approved date, effective date, and expiration date • Services requested (CPT code and description) • Diagnosis (ICD and description) • Services approved to (name of provider or health delivery organization) • Specialty of provider who is authorized for services • Whether claim was submitted and date claim was paid	DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1 CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021~~Q3 2019 - February 15, 2020~~ ~~Q4 2019 - May 15, 2020~~ ~~Q1 2020 - August 15, 2020~~ ~~Q2 2020 - November 15, 2020~~	X			X	X	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). The report includes the following: • Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD • Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons • Reasons for the other denials for dental general anesthesia • Dental general anesthesia reporting comments	APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: 15th of the month after the end of the quarter	X			X	X	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. The UM Evaluation includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review. The UM Program includes a description of the following: • Written description of the program structure • Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program • Behavioral healthcare aspects of the program •The program scope and process used to determine benefit coverage and medical necessity • UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities • Information sources used to determine benefit coverage and medical necessity • The Health Network annually evaluates and updates the UM program, as necessary	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	
UM Work Plan ~~(ICE)~~	Health Networks shall report progress towards UM program goals semi-annually. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM Work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Semi-Annually: February 15 and August 15	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/Under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Annually: February 15 (for new year)	X	X	X	X	X	
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. The report includes the following: • Health Network name, and reporting quarter and year • Date of OON referral request, and referral authorization number • Member name and CIN • Specialist name, NPI, address, and specialty type • Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network) • Resolution status (approved, denied, pending)	APL 20-003: Network Certification Requirements, Network Certification Non-Compliance DHCS Medi-Cal Contract, Exhibit A, Attachment 9	Quarterly: January 25, April 25, July 25, October 25	X			X	X	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information. The report includes the following: • CalOptima claim number and line, Kaiser claim number) • Provider name, NPI and tax identification number • Member CIN and name • Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units. • Kaiser amount billed and paid • CalOptima amount • Claim remittance code and description • Report month and fiscal year • Check date, number and amount	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks. The report includes the following: • Line of business (OneCare, OneCare Connect) • Member name, CIN, date of birth, address, and language • Precluded provider name and NPI • Service type (health care services, health care items, or prescriptions) • Preclusion list impacted membership attestation	HPMS Memo, 11/2/18, Preclusion List Requirements Final Rule, Vol. 83, No. 73, April 2018	Monthly: 10th of every month	X	X	X	X	X	X
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. The report includes the following: • Claim line ID • Health Network ID, claim number, and claim line number • Member name, CIN, and date of service • Clean claim or encounter received date • Whether an adjustment and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT/HCPCS code and modifier (if applicable) • Provider billed amount, and whether contracted provider claim • Claim paid amount and adjustment code (if applicable) • Whether fee-for-service or capitated claim • Directed payment amount and paid date, and check or EFT transaction number • Reimbursement disposition (reserved for CalOptima use) • Optional fields (for unique identifiers/specific to HN to help with reconciliation)	APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services APL 19-015: Proposition 56 Directed Payments for Physician Services APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations APL 20-013: Proposition 56 Directed Payments for Family Planning Services CalOptima Policy FF.2011: Directed Payments CalOptima Health Network Contract, Attachment E-2	Monthly: 10th of every month	X			X	X	
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information. The report includes the following: • Member CIN, date of birth, and MRN (assigned by Kaiser) • Pharmacy NPI and fill date • Prescriber NPI and prescription number • Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag • Drug name, quantity, days of supply, and amount paid • Eligibility for Medi-Cal and CCS • Duplicate record indicator and load date	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. The report includes the following: • Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE) • Organization name • Applicability of General and HIPAA Compliance and FWA Training • Applicability of Compliance Plan and Code of Conduct Requirements • Authorized Signature, Name, Email and Date • Organization Name	CalOptima Policy: HH.2023: Compliance Training CalOptima Health Network Contract, Sections: 3.26 3.27 Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual; 8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS; 9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States; 7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States.	Initial upon contracting; Annually thereafter	X	X	X	X	X	X
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report. The report includes the following: • Health Network name, management company name and report preparer name, title and email. • The reporting year, quarter and month(s). • The number of paid, contested and member-denied claims. • The number of claims paid within timeliness requirements. • The number of unprocessed claims on hand. • The total number of all claims received • The number of emergency room (ER) claims paid, contested and denied. • The number of ER claims paid timely. • Certification signed by principal officer, including name, title, phone and email.	CalOptima Health Network Contract, Section 2.7.8 Kaiser HMO Contract, Section 2.3.8 CalOptima VSP Contract, Section 3.8	Monthly: 15th of every month Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X
274 Provider Directory – Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide. The report includes the following: • Provider and Group name, NPI, TIN, taxonomy and effective/term date(s). • Site name, bed counts, membership min/max, demographics, language(s) spoken, schedule, ownership. • Provider name, membership min/max, demographics, language(s) spoken, schedule, telehealth status.	CalOptima Policy: HH.2003 Health Network and Delegated Entity Reporting; CalOptima Policy: EE.1101 Additions, Changes, and Terminations to Provider Information CalOptima Provider Directory and Web-based Directory; DHCS Medi-Cal Contract: Exhibit A, Attachment 3; NCQA Element MED14B: Pharmacy Directory Data; NCQA Element MED14C: Behavioral Healthcare Directory Data;	Monthly: 2nd of every month	X				X	

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				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
		NCQA Element MED14D: Long-Term Services and Supports Provider Directory Data							
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice. The report includes the following: • Termination Date • Providers Name • Provider Type • Did the Termination Result in One or More of the Annual Network Certification Components to No Longer be Compliant? (Y/N) • Impacted County • Date Member Notice was mailed • Number of Members Impacted (As of Date Notice Received) • Number of Members that were Reassigned Outside of the Time and Distance Standards • Is an Accessibility Analysis or AAS Request Being Submitted with this Report? • Enter the Number of Days' Notice the Provider gave the MCP • Enter the Provider ID • Enter the Provider NPI • Enter the Provider Termination Reason • Indicate if the Provider is CCS Paneled? (Y/N)	CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting; NCQA Element MED1H: Notification of Termination of a Practitioner or Practice Group Standard	Monthly: 15th of the month with all mandatory fields populated	X			X	X	
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals. The report includes the following: • Member Name • ID Number (CIN) • LOB • Request Type • Date the Request was Received • Time the request was received • Was the AR requested as expedited? • Was the AR processed under the expedited timeframe? • Was a timeframe extension taken? • Procedure Codes Requested • Diagnosis Code(s), (ICD-10) • Decision Date • Decision Time • Action (Approved, Modified, Denied) • Authorization Number • Provider Notification Date	CalOptima Health Network Contract Section 4.9.7: Provider Level 1 UM Appeals	Quarterly: 10th of the month following the end of each quarter	X	X	X	X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Provider Notification Time • Provider Written Notification Date • Provider Written Notification Time • Member Written Notification Date • Member Written Notification Time • Threshold Language • Was an Appeal Received (Y/N)? • Date Appeal was Received • Date of Appeal Decision • Decision (Approved, Modified, Denied) • Provider Written Appeal Notification Date								
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR. The report includes the following: • Site ID • Site Address • Suite No. • City • State • Zip • County • Plan# • Health Plan Name • Site Specific Certification #1-#4 • Provider Phone # • Clinic Type • Reviewer ID	DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review NCQA Elements MED 3B and MED 5B	Semi-Annually: February 15 and August 15	X				X	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates. The report includes the following: • Samples of pharmacy information as displayed on Kaiser's website and/or member portal. • Samples showing updates to pharmacy information displayed on Kaiser's website and/or member portal.	NCQA Elements ME 5A, ME 5B, ME 5C, ME 5D	Semi-Annually: April 1 and October 1	X				X	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements. The report includes the following: • Member CIN • COC Request Information (Record Type [Original, Resubmission, Void], Parent COC ID [If Resubmission or Void], COC Receive Date and Type) • COC Benefit Type • COC Disposition • COC Expiration Date • COC Denial Reason Indicator	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Monthly: 1st Tuesday of each month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Submitting and COC Provider NPIs • Provider Taxonomy								

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable: • Access & Availability • Care Delivery Model • Claims • Compliance • Credentialing • Cultural & Linguistics • Customer Service • Encounters • Information Systems • Mailroom Process • Marketing • Medi-Cal Addendum • Member Grievances & Appeals • Network Management • Provider Network Contracting • Provider Relations • Quality Improvement • Sub-Contractual • Translation Services • Utilization Management • Whole Child Model	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13 Medicare Managed Care Manual, Chapter 11, Section 110.2 APL 17-004: Sub-Contractual Relationships and Delegation	Annually: per process	X	X	X	X	X	X
Claims XML Universe	Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0. The report includes the following: • Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process) • CalOptima Line of Business (LOB) • Claim number, form type, bill type in UB04, admission code, place of service name and code • Authorization number • Was claim adjusted and clean • Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10	Monthly: 2nd of every month	X	X	X	X	X	X

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Beneficiary name, Client Identification Number (CIN), threshold language • Requestor type, receipt date and time • Date and time of additional information requested (AIR) • Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status • Rendering provider name, NPI, Tax ID, specialty, contracted status • Medical necessity denials • Date and time claim received, loaded in system, decision made, claim redirected • Payment information method, number, print date and time, transfer date and time • Mail date and time of written notification to member and provider • Decision maker name, title and credentials • International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting • Date of service • Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount • Paid revenue code, description, and CPT/HCPC • Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description • Paid reason for CPT/HCPC change • Decision type and decision denial reason	DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual Chapter 11, Section 110.2 Title 42, Code of Federal Regulations (CFR), Sections: 422.520 (a) 447.45 (d)							

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Paid Claims:</u> • Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date) • Authorization, if applicable • Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable • Proof of check clearing (bank statements or copy of cancelled check) <u>Denied/Contested Claims:</u> • Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date) • Eligibility print screen if contested/denied for eligibility • System notes pertaining to claim • If applicable, denial letters for member liability denials and any supporting documents used to determine the denial • RA/EOB with interest, if applicable <u>Adjustments:</u> • Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt) • Original RA/EOB showing payment or denial • Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.) • Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.) • All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development • RA/EOB with applicable interest • Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10 DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.520 (a) 447.45 (d)	Monthly: 10th of every month	X	X	X	X	X	X

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Health Network name, reporting month and year • Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report • Data ID (IC/RC/TM) • CalOptima program (Medi-Cal, OneCare, OneCare Connect) • Individual practitioner name, license number and type • Contract type and primary contracted specialty • Current and previous credentialing decision dates • Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date • Current facility site review date • Current, signed attestation date • Termination date and reasons for termination • Date Change Termination (CT) form was submitted	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2	<u>Health Networks and Kaiser</u> Monthly: 2nd of every month <u>VSP</u> Quarterly: January 10, April 10, July 10, October 10	X	X	X	X	X	X
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Initial Credentialing</u> • Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter • File checklist • Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Work history, and education and training verification • Board certification verification, as applicable	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners <u>Recredentialing</u> • Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • File checklist • Performance monitoring documentation • Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Board certification verification, as applicable • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners	CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2							
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. The report includes the following: • Member identifier, medical record number, and facility service type • Date of termination request/notice and date of actual termination	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2	Monthly: 2nd of every month		X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt • Date of discharge	Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)							
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. NOMNC files include the following: • Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services • Date of termination request • Date of actual termination (including date, time and name of provider making the request) • Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services) • Member/member's representative notified of appeal rights • Date of termination request/notification signed by the member/member's representative • Copy of signed NONMC letter • Date of discharge If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required: • Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice) • Proof of letter mailed on same date of call made to member's representative • If provider is unable to reach member's representative by phone, provide proof of the following: o Certified mail receipt with return receipt request o Date someone at the representative's address signs or refuses to sign the letter o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)	Monthly: 10th of every month		X	X	X		
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0. The report includes the following: • Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect) • Unique ID number used to track authorization request • Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR • Check number used to pay overturned PDR request, and date and time check was mailed • Date and time the written notification was provided to the provider • Name and title of the decision maker of the PDR request	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2	Monthly: 2nd of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received • Billing provider's name, NPI number, tax ID number, specialty, and whether contracted • Claim number of the original claim being appealed, and decision date and time of the original claim being appealed • Member's name, CIN, and preferred language • ICD type and diagnosis code • Start date and end date of services rendered • Billed revenue code, CPT/HCPC code, and modifier • Billed units and billed amount • Paid amount (excluding interest), withhold amount, and paid interest amount • Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason • Adjustment code and description	Health and Safety Code (HSC), Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, California Code of Regulations (CCR), Section 1300.71.38: (b) (c) (d)							
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: • Copy of original claim, and received date (if electronic claim, a print screen showing received date) • Original RA/EOB showing payment or denial • Provider dispute request along with pertinent documents submitted, and date received • All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development • Acknowledgement letter, and resolution letter sent to provider • EOB showing payment with applicable interest, if original decision of payment denial is overturned • Proof of check clearing (bank statements or copy of cancelled check) if payment is issued	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 HSC, Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, CCR, Section 1300.71.38: (b) (c) (d)	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results. The Provider Directory file review is based on a signed and dated provider attestation that includes the following: • Provider name, California license number, and gender • Address (office locations), office days and hours, day phone number, and after-hours phone number • Administrative email address, or office fax number (if no administrative email available) • Languages spoken by provider and staff • Primary specialty (i.e. dermatology, internal medicate, etc.) • Accepting new patients (i.e., open or closed panel), and age restrictions • Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital) • Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP) • Programs (i.e. Medi-Cal, OneCare, OneCare Connect) • Provider type in this network (i.e. Primary Care Provider, Specialist) • Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number • Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment." • Designated space for printed name, signature and date for the provider office manager or equivalent staff	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Health Network Contract, Section 7.10 CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.17.5.11 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4 HSC, Section 1367.27 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Section 438.10 (h)	Annually, per request	X	X	X	X		

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1. The report includes the following: • Version, as of date, entry identification (ID), and line of business (LOB) for this authorization • ID number used to track the authorization request (AR), and type of AR • Whether authorization is for Part B or physician administered drugs and/or administration • Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist • Method AR was received, and authorization number related to AR • CMS place of service code and name • Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network) • Member name, CIN, and preferred language • AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator) • Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB) • Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received • Requesting provider/group/facility name, NPI, tax ID number, and whether contracted • Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit) • Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date • Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe • If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe • If a request to expedite was made after the original request, identify requestor of subsequent request to expedite • Whether a timeframe extension was taken • Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member • The method used to initially notify the requesting provider of the decision of authorization request • Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream • Whether the review was completed by a physician or other appropriate health care professional • Name, job title, and credentials of the decision maker of the AR • Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description • Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units • Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units • Determination of the requested service • Reason for the denial or modification of the requested service	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1) Medicare Part C Reporting Requirements, Section VI	Monthly: 2nd of every month	X	X	X	X	X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. UM case files include the following documentation: <u>Medi-Cal</u> • Approval file checklist includes all medical records attached to file and transaction log • Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log • Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log <u>OneCare</u> • Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file and transaction log <u>OneCare Connect</u> • Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1)	Monthly: 10th of every month	X	X	X	X	X	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. The report includes the following: • Plan code, name, county and reporting period • Number of CDE referrals • Number of referrals determined appropriate for CDE • Number of CDE completed • Number of CDE appointments scheduled within and outside timely access • Number of CDE not scheduled but offered appointment • Number of CDE with appointment not yet scheduled • Comments	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Monthly: 15th of each month	X				X	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data. The report includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Quarterly: January 20, April 20, July 20, October 20	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Plan code, name, county, reporting quarter and total number of members • Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code • Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description • Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period • Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for • Average number of days taken to deny requests • Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description • Number of COC requests in process and comments								
Case Management Log	Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Member name, CIN, date of birth, and program • Diagnosis and ICD-10 code (qualifying member for case management) • Referral/data source to case management, date opened, and date closed • Case management level, status change reason, and complex case trigger • Additional programs to which member has been referred • Special program to which member is enrolled, or any special needs of member	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 15th of every month	X			X	X	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Identification date for Complex Case Management • Nursing Assessment • Care Notes • Care Plan	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 1 week after CalOptima request	X			X	X	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. The report includes the following: • Requestor type, date of request, and request type	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6	Weekly: Every Tuesday by 10 am for the prior week's activity	X			X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Member name and CIN • COC begin processing date and date of decision • COC completion date (including member notification) and COC expiration date • Requested provider NPI and provider type • Decision outcome, denial reason, and explanation of other reasons • Next steps taken for incomplete requests	Attachment 11, Provision 10							
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. The report includes the following: Health Networks (including Kaiser): • Describe any challenges with care coordination and Health Network's role in overcoming barriers • Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions • For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes Kaiser Only: • Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP • Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Quarterly: 2nd day after the end of the quarter	X			X	X	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. The report includes the following: • Member name, CIN, and date of birth • Whether HHP enrolled member was externally referred • HHP disenrollment date and reason • Whether member is homeless/at risk for homelessness, or received housing services during reporting period • Whether member was homeless at any point during enrollment in HHP • Whether member is no longer homeless as of the last day of reporting period • File create date	DHCS HHP Program Guide CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. The Health Network response file includes the following: • Excluded because not eligible-well managed: Y/N • Excluded because declined to participate: Y/N • Excluded because of unsuccessful engagement: Y/N • Excluded because of duplicative program: Y/N • Excluded because of unsafe behavior or environment: Y/N • Excluded because not enrolled in Medi-Cal at MCP: Y/N	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management	Monthly: 10th of every month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Enrollment date (if applicable)	CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility							
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. The report includes the following: • Claim line ID • Health Network ID, claim number, claim line number • Member name and CIN • Date of service and service provided • Claim or encounter received date • Whether an adjustment, and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT code and modifier, and primary diagnosis • Units billed and provider billed amount • Paid amount, and adjustment code • Fee-for-service or capitated claim • Check or EFT transaction number • Optional user defined fields	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements, Section A. Care Plans Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA1.5 CA1.6 CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements	Ongoing, per process			X	X		
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes								
Implementation Audit (Seniors and Persons with Disabilities (SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Organ Transplant – Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process. The report includes the following: • Member name, CIN, and date of birth • Transplant related diagnosis and transplant type • DHCS-approved transplant center where member will be transplanted • Date the Health Network notified CalOptima of member's potential transplant status • Current transplant phase and the date the phase began • Date member is listed for transplant at DHCS-approved transplant center • Date member was last contacted regarding case management/coordination care issues • Date the transplant case is closed and reason for case closure • Case manager name • Additional comments to clarify report	APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions Cal MediConnect 3-Way Contract, Section 2.2.4	Monthly: 15th of every month	X				X	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. The report includes the following: • Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination. • WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Section 6 Attachment 11, Section 10	Ongoing, per process	X			X	X	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date. The report includes the following:	Medi-Cal Health Homes Program Guide APL 18-012: Health Homes Program Requirements	Ongoing, per process	X			X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills. • Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals. • Clinical assessments/case management notes								
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA 1.1 - CA 1.5 OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 Medicare Managed Care Manual, Chapter 5, Sections: 20.2.1 2.C and D DPL 15-001: ICP and ICT Requirements	Ongoing, per process			X	X		
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following:	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP								
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Final ICP that includes assessments, interventions, and goals set by the facility • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2	Ongoing, per process			X	X		
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. The report includes the following: • ICT notes/minutes, participants invited according to member's needs, and ICT attendees • Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Copy of Care Planning Letter sent to Member with date mailed and preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2	Monthly: 6th of every month	X			X	X	

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REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1	Monthly: 6th of every month			X	X		
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month		X		X		
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Monthly: 6th of every month	X			X		
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Staff name, number (unique for each individual PCC or CC, phone number, and email • For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments • Model of Care (MOC) training received • PCC training received and PCC staffing ratio met • Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Type of licensed staff or non-licensed CC staff • Attestation from Manager/Director (name and title) to report information								
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Ongoing, per process	X			X	X	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date • Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider • Number of other WCM grievances and summary of such grievances • Number of WCM appeals and summary of appeals	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4 Attachment 11, Provision 10	Monthly: 15th of every month	X				X	
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review. The report includes the following: • Quantitative results for relevant clinical, cost/utilization and experience measures • Comparison of results with a benchmark	NCQA Standards, Population Health Management, PHM7	Annually: February 15th	X				X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11 Provision 10	Monthly: 15th of every month	X			X		
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure codes(s) and description of services rendered • Amount subcontractor or out-of-plan Provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL) APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements Cal MediConnect 3-Way Contract, Section 5.1.13.1 DHCS Medi-Cal Contract, Exhibit E, Attachment 2	Monthly: 30th of every month	X			X	X	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure code(s) and description of services rendered • Amount subcontractor or out-of-plan provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability Title 42, CFR, Sections: 405.378 411.24 422.108 423.462 CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights" Cal MediConnect 3-Way Contract, Section 5.1.13	Monthly: 30th of every month			X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima. The report includes the following: • Project type (Third Part Liability "TPL") • Name of Provider billing the claim, and provider tax ID number • Claim type (What kind of claim was submitted, Facility, Professional, etc.) • Member name, date of birth, ID number, and social security number • Transaction control number (claim number) • Begin date and end date of service • Coordinated care organization bill amount (amount billed to TPL/Provider) • Coordinated care organization paid amount (amount paid to the Provider) • Bill date (date the claim was billed to the TPL) • Remit amount (amount recovered from the TPL) • Claim date of remit (date the claim was paid or denied by TPL) • Check number related to remit amount • Other insurance carrier name (name of the TPL that was billed) • Claim status (disposition of the claim, paid, denied, open, etc.) • Denial reason (the reason the claim was denied by the TPL)	APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage	Monthly: 3rd business day of every month	X			X	X	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. The report includes the following: • File ID number, and line of business • Member name and cardholder ID (assigned by HN to identify member) • Date and time the call was received • Category of the call and detailed description of the call • Detailed description of the outcome/resolution of the call • Date and time the call was resolved • Customer Service Representative name who handled the call • Member's language	DHCS Medi-Cal Contract, Exhibit A: Attachment 13, Provision 2 Attachment 14, Provision 1 Attachment 14, Provision 2 Health and Safety Code (HSC), Section 1368(a)(1) Title 28, CCR, Section 1300.68(a) Cal MediConnect 3-Way Contract, Section 2.14 Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance NCQA Element MED12D: Providing Information to Medicaid Members in the Practitioner Directory (Kaiser)	Quarterly: January 7, April 7, July 7, October 7	X	X	X	X	X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review. The report includes the following: • Total number of calls, average speed of answer, and average length of call in seconds • Service levels (percentage of incoming calls answered within 30 seconds) • Average speed to answer member services telephone calls with a live voice • Abandonment rate (percentage of incoming calls disconnected) • Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services) • Number of calls by language	CalOptima Health Network Contract, Sections: 3.5 7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3	Monthly; 15th of every month	X	X	X	X	X	X
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. The report includes the following: • Requests for interpreter services by language (number of requests received, and number of requests fulfilled) • Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff • Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff • Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted)	DHCS Medi-Cal Contract, Exhibit A, Attachment 6 Cal MediConnect 3-Way Contract, Section 2.11.1.2.2	Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X
DHCS NMT/NEMT Report – Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT denials • Number of NMT and NEMT calls • Number of NMT and NEMT grievances, and grievance reasons • NMT/NEMT reporting comments	APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services DHCS Medi-Cal Contract, Exhibit A, Attachment 10 Welfare and Institutions Code, Section 14132	Monthly: 27th of every month	X				X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). Audited financial statements include the following: • Letters to management, and incurred but not reported (IBNR) documentation • Consolidated corporate audited financial statements (if Health Network is part of a larger entity) • Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. The IBNR documentation includes the following: • Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims • Supporting documentation for the IBNR calculation	CalOptima Policy FF.3001 Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR. MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	CalOptima Policy FF.3001: Financial Reporting	Interim: January - June due August 15 Interim: January - December due February 15 Final: Annual submission of all 12 months due June 30	X		X	X		
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3.	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 150 days after the fiscal year ends Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization. Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures.	CalOptima Policy FF.3001: Financial Reporting	Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Year, quarter, plan code, member CIN • Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other • For the other category, grievance type(s) must be defined by HN • Whether grievance was resolved (in favor of member or HN) or unresolved	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3 APL 14-013: Grievance Report Template APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments	Quarterly: January 23, April 23, July 23, October 23	X				X	
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other • Total of all grievance types	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3	Quarterly: January 23, April 23, July 23, October 23	X				X	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, reporting quarter • Number of requests for CBAS, and number of CBAS Providers • Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services • Average number of days between CBAS request and notice of eligibility • Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center • Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances • Number of CBAS appeals approved, denied, and withdrawn • Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS • Number of CBAS complaint calls from member and from provider • Explanations and summary of CBAS complaints • CBAS reporting comments	CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6	Quarterly: January 23, April 23, July 23, October 23	X				X	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.	APL 17-005: Certification of Document and Data Submissions	Monthly: 25th of each month	X			X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The most current template Data Certification Statement in the Report Binder shall be utilized and include the following: • Health Network name, certification month and year • Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer) • Signature date, job title, and Health Network department.	DHCS Medi-Cal Contract, Exhibit E, Attachment 2 CalOptima Health Network Contract, Section 7.12							
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. The report includes the following: • Program (Medi-Cal, OneCare, OneCare Connect) • Provider name, NPI, and active status date • Date the training started and date the training was completed • Whether signed acknowledgment was received from provider • Comments/explanation of missed deadline(s)	CalOptima Policy EE.1103: Provider Education and Training DHCS Medi-Cal Contract, Exhibit A: Attachment 7, Provisions 5 Attachment 9, Provision 12 APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities Cal MediConnect 3-Way Contract, Section 2.9.11	Quarterly: January 25, April 25, July 25, October 25	X	X	X	X	X	X
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. The report includes the following: • Member site, ID, and suffix • PCP effective date, ID, and suffix • Health Network ID and suffix • Medical center ID and suffix • Staff Vs center indicator • Pay to Tax ID number (Health Network Tax ID) • Pay to Tax ID suffix • PCP reason code • Name of individual provider, group, or clinic	CalOptima Health Network Contract, Sections: 3.12 7.1 7.11 CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4 CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP)	Bi-monthly: 10th and 25th of every month	X			X		
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. The report includes the following: • Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI). • Member name and CIN • Health Care Plan (HCP) code • Month of service • Member enrollment status indicator • Services rendered	DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16 Technical Guidance: Consolidated Supplemental Upload Process	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Diagnosis date • Delivery date • Number of weeks for Hep-C multiplier • Indicator for correction record • Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret • Number of encounters								
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories. The report includes the following: • Practice name, doctor name, and provider specialty • Provider address, phone number, and county name • Non-English languages spoken by provider and/or clinical staff • Provider NPI, license number and type, special experience, and gender • Accepting new patients, and ages seen • Hours of operation from Monday through Sunday	CalOptima VSP Contract, Sections: 1.17 7.1	Monthly: 15th of every month	X					X
Health Education Calendar - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes. The report shall include, at a minimum: • Class or program name • Location • Date and time	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Individual Encounters-Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Other Encounters - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs.	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The report shall include, at a minimum: • Class or program • Number of members in attendance								
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts. The data include the following: • Member CIN • Member DOB • Estimated Delivery Date • Participating in CPSP (Y/N) • Date CPSP Initiated	CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7	Monthly: 15th of every month	X				X	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. The report includes the following: • Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access • Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access • Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services • Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network • Documenting at least one intervention and measure effectiveness of interventions (if applicable)	DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation DHCS Proposed Annual Network Certification Policy Changes NCQA Standards, Network Management: Net 1B – 1D Net 2A – 2C Net 3A – 3C CalOptima Policy GG.1600: Access and Availability Standards CalOptima Policy MA.7007: Access and Availability Title 28, CCR, Sections: 1300.67.2 1300.67.2.1 1300.67.2.2 DHCS Medi-Cal Contract, Exhibit A: Attachment 6 Attachment 9 Cal MediConnect 3-Way Contract, Section 2 Title 42, CFR, Section 438.206-207	Annually: February 15	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Quality Improvement (QI) Evaluation (Previous Year) – Kaiser	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. The evaluation includes the following: • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service • Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	
QI Program – Kaiser	Kaiser shall develop an annual QI program description and submit to CalOptima for review. The program includes description of the following: • The QI program structure • The behavioral healthcare aspects of the program • Involvement of a designated physician in the QI program • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program • Oversight of QI functions of the organization by the QI Committee • Objectives for serving a culturally and linguistically diverse membership	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	
QI Work Plan – Kaiser	Kaiser shall report progress towards quality improvement program goals semi-annually. The QI work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Semi-Annually: February 15 and August 15	X				X	
QI Work Plan Current Year (Initial) – Kaiser	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually; February 15 (for new year)	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Report of Findings and Actions Taken as a Result of QI Activities – Kaiser	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities. The report includes the following, at a minimum: • Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions) • An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB)	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Quarterly	X				X	
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). The report includes the following: • Member name, Client Identification Number (CIN), and date of birth • Health Network name or number, and PCP name • Authorization tracking/case number • Authorization request date, approved date, effective date, and expiration date • Services requested (CPT code and description) • Diagnosis (ICD and description) • Services approved to (name of provider or health delivery organization) • Specialty of provider who is authorized for services • Whether claim was submitted and date claim was paid	DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1 CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021	X			X	X	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). The report includes the following: • Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD • Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons • Reasons for the other denials for dental general anesthesia • Dental general anesthesia reporting comments	APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: 15th of the month after the end of the quarter	X			X	X	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. The UM Evaluation includes the following: • The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review. The UM Program includes a description of the following: • Written description of the program structure • Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program • Behavioral healthcare aspects of the program •The program scope and process used to determine benefit coverage and medical necessity • UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities • Information sources used to determine benefit coverage and medical necessity • The Health Network annually evaluates and updates the UM program, as necessary	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	
UM Work Plan	Health Networks shall report progress towards UM program goals semi-annually. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM Work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Semi-Annually: February 15 and August 15	X	X	X	X	X	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Annually: February 15 (for new year)	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/Under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. The report includes the following: • Health Network name, and reporting quarter and year • Date of OON referral request, and referral authorization number • Member name and CIN • Specialist name, NPI, address, and specialty type • Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network) • Resolution status (approved, denied, pending)	APL 20-003: Network Certification Requirements, Network Certification Non-Compliance DHCS Medi-Cal Contract, Exhibit A, Attachment 9	Quarterly: January 25, April 25, July 25, October 25	X			X	X	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information. The report includes the following: • CalOptima claim number and line, Kaiser claim number) • Provider name, NPI and tax identification number • Member CIN and name • Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units. • Kaiser amount billed and paid • CalOptima amount • Claim remittance code and description • Report month and fiscal year • Check date, number and amount	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks. The report includes the following: • Line of business (OneCare, OneCare Connect) • Member name, CIN, date of birth, address, and language • Precluded provider name and NPI • Service type (health care services, health care items, or prescriptions) • Preclusion list impacted membership attestation	HPMS Memo, 11/2/18, Preclusion List Requirements Final Rule, Vol. 83, No. 73, April 2018	Monthly: 10th of every month	X	X	X	X	X	X
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. The report includes the following: • Claim line ID • Health Network ID, claim number, and claim line number • Member name, CIN, and date of service • Clean claim or encounter received date • Whether an adjustment and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT/HCPCS code and modifier (if applicable) • Provider billed amount, and whether contracted provider claim • Claim paid amount and adjustment code (if applicable) • Whether fee-for-service or capitated claim • Directed payment amount and paid date, and check or EFT transaction number • Reimbursement disposition (reserved for CalOptima use) • Optional fields (for unique identifiers/specific to HN to help with reconciliation)	APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services APL 19-015: Proposition 56 Directed Payments for Physician Services APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations APL 20-013: Proposition 56 Directed Payments for Family Planning Services CalOptima Policy FF.2011: Directed Payments CalOptima Health Network Contract, Attachment E-2	Monthly: 10th of every month	X			X	X	
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information. The report includes the following: • Member CIN, date of birth, and MRN (assigned by Kaiser) • Pharmacy NPI and fill date • Prescriber NPI and prescription number • Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag • Drug name, quantity, days of supply, and amount paid • Eligibility for Medi-Cal and CCS • Duplicate record indicator and load date	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. The report includes the following: • Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE) • Organization name • Applicability of General and HIPAA Compliance and FWA Training • Applicability of Compliance Plan and Code of Conduct Requirements • Authorized Signature, Name, Email and Date • Organization Name	CalOptima Policy: HH.2023: Compliance Training CalOptima Health Network Contract, Sections: 3.26 3.27 Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual; 8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS; 9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States; 7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States.	Initial upon contracting; Annually thereafter	X	X	X	X	X	X
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report. The report includes the following: • Health Network name, management company name and report preparer name, title and email. • The reporting year, quarter and month(s). • The number of paid, contested and member-denied claims. • The number of claims paid within timeliness requirements. • The number of unprocessed claims on hand. • The total number of all claims received • The number of emergency room (ER) claims paid, contested and denied. • The number of ER claims paid timely. • Certification signed by principal officer, including name, title, phone and email.	CalOptima Health Network Contract, Section 2.7.8 Kaiser HMO Contract, Section 2.3.8 CalOptima VSP Contract, Section 3.8	Monthly: 15th of every month Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X
274 Provider Directory – Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide. The report includes the following: • Provider and Group name, NPI, TIN, taxonomy and effective/term date(s). • Site name, bed counts, membership min/max, demographics, language(s) spoken, schedule, ownership. • Provider name, membership min/max, demographics, language(s) spoken, schedule, telehealth status.	CalOptima Policy: HH.2003 Health Network and Delegated Entity Reporting; CalOptima Policy: EE.1101 Additions, Changes, and Terminations to Provider Information CalOptima Provider Directory and Web-based Directory; DHCS Medi-Cal Contract: Exhibit A, Attachment 3; NCQA Element MED14B: Pharmacy Directory Data; NCQA Element MED14C: Behavioral Healthcare Directory Data;	Monthly: 2nd of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
		NCQA Element MED14D: Long-Term Services and Supports Provider Directory Data							
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice. The report includes the following: • Termination Date • Providers Name • Provider Type • Did the Termination Result in One or More of the Annual Network Certification Components to No Longer be Compliant? (Y/N) • Impacted County • Date Member Notice was mailed • Number of Members Impacted (As of Date Notice Received) • Number of Members that were Reassigned Outside of the Time and Distance Standards • Is an Accessibility Analysis or AAS Request Being Submitted with this Report? • Enter the Number of Days' Notice the Provider gave the MCP • Enter the Provider ID • Enter the Provider NPI • Enter the Provider Termination Reason • Indicate if the Provider is CCS Paneled? (Y/N)	CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting; NCQA Element MED1H: Notification of Termination of a Practitioner or Practice Group Standard	Monthly: 15th of the month with all mandatory fields populated	X			X	X	
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals. The report includes the following: • Member Name • ID Number (CIN) • LOB • Request Type • Date the Request was Received • Time the request was received • Was the AR requested as expedited? • Was the AR processed under the expedited timeframe? • Was a timeframe extension taken? • Procedure Codes Requested • Diagnosis Code(s), (ICD-10) • Decision Date • Decision Time • Action (Approved, Modified, Denied) • Authorization Number • Provider Notification Date	CalOptima Health Network Contract Section 4.9.7: Provider Level 1 UM Appeals	Quarterly: 10th of the month following the end of each quarter	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Provider Notification Time • Provider Written Notification Date • Provider Written Notification Time • Member Written Notification Date • Member Written Notification Time • Threshold Language • Was an Appeal Received (Y/N)? • Date Appeal was Received • Date of Appeal Decision • Decision (Approved, Modified, Denied) • Provider Written Appeal Notification Date								
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR. The report includes the following: • Site ID • Site Address • Suite No. • City • State • Zip • County • Plan# • Health Plan Name • Site Specific Certification #1-#4 • Provider Phone # • Clinic Type • Reviewer ID	DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review NCQA Elements MED 3B and MED 5B	Semi-Annually: February 15 and August 15	X				X	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates. The report includes the following: • Samples of pharmacy information as displayed on Kaiser's website and/or member portal. • Samples showing updates to pharmacy information displayed on Kaiser's website and/or member portal.	NCQA Elements ME 5A, ME 5B, ME 5C, ME 5D	Semi-Annually: April 1 and October 1	X				X	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements. The report includes the following: • Member CIN • COC Request Information (Record Type [Original, Resubmission, Void], Parent COC ID [If Resubmission or Void], COC Receive Date and Type) • COC Benefit Type • COC Disposition • COC Expiration Date • COC Denial Reason Indicator	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Monthly: 1st Tuesday of each month	X			X	X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Submitting and COC Provider NPIs • Provider Taxonomy								

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
31. Consider Authorizing Extension and Amendments of the Fee-For-Service Hospital Contracts for Medi-Cal, OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly

Contacts
Ladan Khamseh, Chief Operating Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer (CEO) to extend the terms of existing CalOptima Fee-for-Service (FFS), hospital contracts through June 30, 2022, and, with the assistance of Legal Counsel, to enter into amendments of those contracts to:

1. Standardize reimbursement rates for Medicare-based programs OneCare (OC), OneCare Connect (OCC), and Program of All-Inclusive Care for the Elderly (PACE);
2. Reflect updated Medi-Cal reimbursement for contracted FFS hospitals' All Patients Refined-Diagnosis Related Groups (APR-DRG) and blended per diem-based schedule, as applicable;
3. Reflect updated Medi-Cal reimbursement rates for contracted FFS hospital outpatient services, other than hospital-administered drugs; and
4. Reflect updated Medi-Cal reimbursement for outpatient hospital-administered drugs.

Background/Discussion
CalOptima currently contracts on a fee-for-service basis with hospitals to provide services to Medi-Cal, OneCare, OneCare Connect Members assigned to CalOptima Direct and Shared Risk groups, as well as PACE members. These hospital contracts extend on an annual basis, contingent upon approval from the CalOptima Board of Directors.

Current contracts with all FFS hospitals expire on June 30, 2021. Staff seeks to extend all existing FFS hospital contracts until June 30, 2022 and amend per the terms below. The proposed amendments include:

- In an effort to standardize rates, language will be added to reflect reimbursement rates for Medicare-based programs OC, OCC and PACE contracts at 100% of the Medicare Allowable pricing for all contracted FFS hospitals.

- Medi-Cal reimbursement rates for contracted acute care hospitals will be increased from 108% to 112% of APR-DRG for Inpatient Classic members and an equivalent increase will be applied to contracted FFS hospitals that remain with a per diem fee schedule. This does not apply to long-term acute care facilities. The increase aligns with CalOptima's focus on adjusting certain service categories, as needed, to ensure member access to quality care and network adequacy post COVID-19 pandemic.

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- Medi-Cal reimbursement rates for contracted hospital outpatient services, other than hospital-administered drugs will be increased from 133% to 140% of the Medi-Cal Fee Schedule. This increase aligns with CalOptima's focus on adjusting certain service categories, as needed, to ensure member access to quality care and network adequacy post COVID-19 pandemic.

- Medi-Cal reimbursement rates for outpatient hospital administered drugs will be decreased from 133% to 100% of the Medi-Cal Fee Schedule. This change aligns with the Department of Health Care Services efficiency standards that will be applied for pharmacy in the upcoming year.

To ensure continuity of access to care and support the stability of CalOptima's contracted FFS hospital network for all Medi-Cal, OC, OCC and PACE members, staff requests approval of all proposed amendments for all contracted FFS hospitals and extension of contracts through June 30, 2022.

Fiscal Impact
Management has included costs associated with CalOptima FFS hospital contracts in the proposed CalOptima Fiscal Year (FY) 2021-22 Operating Budget pending Board approval. The annual fiscal impact of the proposed rate changes are as follows:

Medi-Cal program

- 3.75% increase to inpatient hospital rates are projected to increase hospital claims expenses by $4.1 million per year;
- 5.2% increase to outpatient hospital non-drug rate from 133% to 140% of the Medi-Cal fee schedule is projected to increase hospital claims expense by $2.9 million per year; and
- 24.8% reduction to outpatient hospital administered drugs is projected to decrease hospital claims expense by $4.0 million per year.

OneCare Connect, OneCare, PACE programs: 1.35% increase to inpatient hospital rates are projected to increase hospital claims expenses by $492,000 per year.

Rationale for Recommendation
CalOptima staff recommends this action to support the stability of CalOptima's contracted FFS hospital network, maintain and continue the contractual relationship with the hospital network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Action
2. Medi-Cal Full-Risk HMO, SRG, and PHC Health Network Contract Amendment Template
3. Medi-Cal, OneCare, OneCare Connect and PACE FFS Hospital Contract Template

/s/ Richard Sanchez — *05/26/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
Childrens Hospital of Los Angeles	4650 W Sunset Blvd MS 87	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
College Hospital - Cerritos	10802 College Place	Cerritos	CA	90703
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Hoag Memorial Hospital Presbyterian	16200 San Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Keck Medical Center of USC	1500 San Pablo St	Los Angeles	CA	90033
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 Rose Dr	Placentia	CA	92870
Prime HealthCare La Palma Intercommunity Hosp	7901 Walker St	La Palma	CA	90623
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital	31872 Coast Hwy	Laguna Beach	CA	92651
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence St. Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St. Joseph Hospital Orange	1100 W Stewart Dr	Orange	CA	92868
Providence St. Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Providence St. Jude Medical Center - Rehab Unit	101 E Valencia Mesa Dr	Fullerton	CA	92835
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
UCI Medical Center	101 The City Dr South	Orange	CA	92868
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605

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AMENDMENT I TO
HOSPITAL SERVICES CONTRACT

THIS AMENDMENT I TO THE HOSPITAL SERVICES CONTRACT ("Amendment I") is effective as of July 1, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend this Contract to revise compensation and CalOptima programs, including Medicare Advantage (OneCare) which is being added to this Contract and will supersede any and all prior contracts for OneCare.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "Hospital Services", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I, "Hospital Services".

2. Attachment B, "Compensation", shall be deleted in its entirety and replaced with the attached Attachment B – Amendment I, "Compensation".

3. Attachment B-1, "Medi-Cal Compensation Rates for Adult Expansion Members", shall be deleted in its entirety and replaced with the attached Attachment B-1 – Amendment I, "Medi-Cal Compensation Rates for Adult Expansion Members".

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	Ladan Khamseh
Print Name	Print Name
_____	Chief Operation Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A – AMENDMENT I

HOSPITAL SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Hospital shall furnish covered services to eligible members in the following CalOptima Programs:

___X__	Medi-Cal Program
___X__	OneCare Program
___X__	Cal MediConnect Program/OneCare Connect
___X___	PACE Program

ARTICLE 2
HOSPITAL SERVICES

2.1. Hospital is responsible for providing all covered Hospital Services, as authorized by CalOptima or designee, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary, including but not limited to:

1. Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2. Hospitalization in an intensive care unit or special care unit;
3. Pediatric services;
4. Maternity services;
5. Psychiatric and substance abuse services;
6. Newborn nursery, all levels;
7. Ancillary services and supplies, including laboratory and radiology services;
8. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
9. Emergency Department Services (as provided in Section 2.3 of this Contract, Emergency Services do not require prior authorization);
10. Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s); and
11. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

ATTACHMENT B – AMENDMENT I

COMPENSATION

For Covered Services provided to CalOptima Medi-Cal Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal
(For Medi-Cal Expansion Members please see Attachment B-1)

Inpatient Services

All inpatient facility services shall be paid at XX% of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. CalOptima Policy FF.1005c: Special Payments: High Cost Exclusion Items shall not apply to any inpatient services under this Contract.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Acute administrative days shall be paid at 100% of the Medi-Cal reimbursement and per CalOptima's policy regarding the criteria for authorizing acute administrative days.
Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

II. Medicare Advantage (OneCare)

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. Cal MediConnect (OneCare Connect)

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

IV. PACE

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

ATTACHMENT B-1

MEDI-CAL COMPENSATION RATES FOR ADULT EXPANSION MEMBERS

Compensation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will amend the Contract to adjust payments made to the Hospital.

For Covered Services provided to CalOptima Medi-Cal Adult Expansion Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Inpatient Services

All inpatient facility services shall be paid at XX% of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. CalOptima Policy FF.1005c: Special Payments: High Cost Exclusion Items shall not apply to any inpatient services under this Contract.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Acute administrative days shall be paid at 100% of the Medi-Cal reimbursement and per CalOptima's policy regarding the criteria for authorizing acute administrative days.
Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

AMENDED AND RESTATED

HOSPITAL SERVICES CONTRACT

This Hospital Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Hospital"), a California Corporation, with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract"). This program will begin operation, subject to final approval of DHCS and CMS, no sooner than July 1, 2015.

E. CalOptima desires to provide services and Hospital is willing to provide services to dually eligible Medi-Cal and Medicare Enrollees to receive full benefits under Medicare and Medi-Cal.

F. Hospital is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima desires to engage Hospital to furnish, and Hospital desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Hospital desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in attachments and schedules attached hereto, apply to the terms set forth in this contract:

1.1. “Accreditation organization” means any organization including without limitation, the national committee for quality assurance (**NCQA**), joint commission on accreditation of healthcare organizations (**JCAHO**) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, hospital and/or their respective programs, centers or services**.**

1.2. "adult expansion member” means a member enrolled in aid codes designated by the State, including L1 and M1, as newly eligible who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3. “Advance Directive” means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

1.4. "Cal MediConnect" means a CalOptima Program which furnishes health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.5. “California Children’s Services (CCS)” means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.6. “California Children’s Services (CCS) Eligible Condition(s)”, means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.7. “California Children’s Services (CCS) Program” means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.8. “CalOptima Direct” or “COD” means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network.

1.9. “CalOptima Policies” means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.10. “CalOptima Programs” means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Hospital participates in the specific CalOptima Program(s) identified on Attachment A.

1.11. "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its FDR’s activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General, the Department of Health and Human Services and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.12. “CCS Provider” or “CCS-Paneled Provider(s)” means any of the following providers when used to treat Members for a CCS Eligible Condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.13. “Claim” means a request for payment submitted by Hospital in accordance with this Contract and CalOptima Policies.

1.14. “Clean Claim” means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

1.15. “Compliance Program” means the program (including, without limitation, the compliance plan, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima’s operations and practices and the practices of the members of its Board of Directors, employees, contractors and Hospitals comply with applicable law and ethical standards.

1.16. "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.17. “Covered Services” means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision

1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.18. "Downstream Entity" means all persons or entities with which Hospital has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Hospital's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Hospital" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities as defined herein even if not expressly referenced in the particular provision.

1.19. "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.20. "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

1.21. "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Hospital and Hospital Providers are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

1.22. "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.23. “Enrollee” means a Medi-Cal/Medicare eligible individual who is enrolled in the CalOptima Cal MediConnect Program, or OneCare Program and may also be referred to as Member.

1.24. “Family Planning” means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.25. “First Tier, Downstream and Related Entity” or “FDR” means a party that enters into a written agreement (acceptable to CMS and DHCS) to provide administrative or health care services to CalOptima under the DHCS/CMS Cal MediConnect Contract.

1.26. “Government Agencies” means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and MRMIB and their respective agents and contractors, including quality improvement organizations (QIOs).

1.27. “Government Contract(s)” means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.28. “Government Guidance” means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

1.29. “Health Network” means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members.

1.30. “Hospital Services” means those Medically Necessary inpatient and outpatient services, including medical services and supplies that are Covered Services and that Hospital will provide to Members as identified in Attachment A.

1.31. “Licenses” means all licenses and permits that Hospital is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.32. “Long Term Care Facility” means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

1.33. “Low Income Health Program” or “LIHP” Member means an Adult Expansion Member who was formerly a LIHP enrollee and transitioned to Medi-Cal under aid code L1.

1.34. “Medi-Cal” is the name of the Medicaid program for the State of California (*i.e.*, the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.35. “Medical Necessity” or “Medically Necessary” means reasonable and necessary services to protect life, prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.36. “Medical Record” means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws.

1.37. “Medicare” means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.38. “Medicare Secondary Payer” or “MSP” means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

1.39. “Member” means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program.

1.40. “Memorandum/Memoranda of Understanding” or “MOU” means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.41. “Minimum Provider Standards” means the minimum participation criteria established by CalOptima for specified Providers that must be satisfied in order for a Provider to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima members as identified in CalOptima Policies.

1.42. “Non-Covered Services” means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

1.43. “Non-Participating Provider” means an institutional, professional or other Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

1.44. “Participating Provider” means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.45. “Participation Status” means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.46. “Physician” means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

1.47. “Preclusion List**”** means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries

1.48. “Post-stabilization Services” means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under circumstances described in 42 CFR 438.114(e) to improve or resolve the Member’s condition.

1.49. “Prior Authorization” means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

1.50. “Program of All-Inclusive Care for the Elderly” or “PACE” means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee’s needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants’ care. All PACE program requirements and services will be managed directly through CalOptima.

1.51. “Provider” means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

1.52. “Provider Manual” means that document, as amended from time to time, that is prepared by CalOptima and describes CalOptima’s Policies as they affect Providers.

1.53. “QMI Program” means CalOptima Quality Management and Improvement Program.

1.54. “Referral” means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

1.55. "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

1.56. "Subcontract" means a contract entered into by Hospital with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Hospital fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.57. "Subcontractor" means a Provider or any organization or person who has entered into Subcontract with Hospital for the purposes of providing or facilitating the provision of items and/or services under this Contract.

1.58. "Threshold Languages/Concentration Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

1.59. "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

1.60. "Urgently Needed Services" means medically necessary Hospital Services that are not Emergency Services, provided generally when the Member is temporarily absent from the CalOptima service area as described in this Contract, and which are immediately required as a result of an unforeseen illness, injury or condition and for which it was not reasonable, given the circumstances, to obtain the services through the Member's Health Network.

1.61. "UM Program" means CalOptima's Utilization Management Program.

1.62. "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF HOSPITAL

2.1. Provision of Hospital Services.

2.1.1. Hospital shall furnish Hospital Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

Hospital agrees that, to the extent feasible and within available capacity and capability, Hospital Services provided by it will be made available and accessible

to Members promptly and in a manner that ensures continuity of care and compliance with Section 2.6 of this Contract.

2.1.2. Throughout the term of this Contract, and subject to the conditions of the Contract, Hospital shall maintain the quality of its services and personnel in accordance with the requirements of this Contract, to meet Hospital's obligation to provide Hospital Services hereunder.

2.1.3. In accordance with Section 2.34 of this Contract, Hospital and its Subcontractors shall furnish Hospital Services to Members under this Contract in the same manner as those services are provided to other patients and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

2.2. Hospital Providers. Upon request, Hospital shall provide CalOptima with a list of Hospital medical staff members, together with any information requested by CalOptima for the administration of its QMI Program, unless such information is protected under California Evidence Code Section 1157 or other privilege statute. If a member of Hospital's medical staff is debarred from participation in a state or federal health care program and/or has his/her license to practice medicine suspended or revoked, Hospital shall recommend that the Hospital medical staff immediately prevent the physician from providing any professional services to Members. Hospital shall immediately notify CalOptima of any physician who has been debarred from participating in a state or federal health care program, or whose license to practice medicine has been suspended or revoked.

2.3. Emergency Services. Hospital shall comply with all applicable State and Federal laws and regulations governing the provision and payment of Emergency Services including, without limitation, the following requirements:

2.3.1. Hospital shall furnish Emergency Services on a twenty-four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Hospital for Emergency Services without Prior Authorization.

2.3.2. Payment will not be denied to Hospital where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 1.17 above or where CalOptima or one of its Participating Providers instructs the Member to seek Emergency Services.

2.3.3. An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

2.3.4. The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

2.4. Notification of Emergency Services. Hospital agrees to notify CalOptima within twenty-four (24) hours of a CalOptima Member's Initial Emergency Encounter which means the Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first. If the Initial Emergency Encounter is on a holiday or weekend, notification to the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence. Hospital agrees that CalOptima's UM staff shall have access to timely information and documentation in order to enable CalOptima to review emergency admissions in order to certify the number of inpatient days authorized under the UM Program. Emergency Services provided within twenty-four (24) hours of an inpatient admission will be included in the inpatient per diems and/or case rates.

2.5. Members with Disabilities. Hospital will accommodate inpatient and outpatient surgical and medical procedures for members with disabilities**,** including but not limited to dental procedures under general anesthesia, to the extent that Hospital can provide such services.

2.6. UM Program. Hospital shall comply with CalOptima's UM Program including:

2.6.1. Hospital acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Hospital Services, to Members. Hospital shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Hospital Services as described in this Contract.

2.6.2. Hospital shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies. Prior Authorization is not required for Emergency Services.

2.6.3. Hospital agrees to allow CalOptima staff to initiate visits with Hospital staff immediately upon admission of any Member to evaluate the appropriateness of the admission and continued stay.

2.6.4. Except for Emergency Services, Hospital agrees to admit members to Hospital only upon presentation to Hospital of the proper Referral form or authorization information designated by CalOptima (and/or a Health Network) certifying the Hospital Services and the number of inpatient days authorized under the UM Program. Hospital shall provide non-emergency Hospital Services to Members during the term of this Contract only upon CalOptima's prior authorization unless prior authorization is not required for a particular item or service under the CalOptima Program. Failure to secure prior authorization from the CalOptima Utilization Management Department may result in denial of claims submitted to CalOptima. In the event a Referral is not presented, Hospital may admit a Member if it verifies, prior to admission, that the admission is approved by CalOptima and in accordance with the policies and procedures of CalOptima's

UM Program. Hospital shall obtain a tracking number from CalOptima at the time of admission, which Hospital shall indicate on all UB-92 Forms submitted to CalOptima for payment. In the event Hospital does not request a CalOptima authorization and Hospital does not receive CalOptima's authorization prior to admission, CalOptima shall not pay Hospital for such admission.

2.6.5. Hospital agrees to obtain authorization for all admissions by notifying CalOptima within 24 hours or the next business day from time of the admission or time Member identity is known, or would have been known with the exercise of reasonable diligence. Hospital also agrees to request authorization for all admissions to Long Term Care Facilities. Furthermore, Hospital agrees to cooperate with CalOptima in the functions of discharge planning and transferring Members to participating providers as is appropriate for all levels of care required by the Member and in accordance with CalOptima Policies. Hospital's failure to obtain pre-authorizations and /or provide timely concurrent reviews may result in a reduction in payment in accordance with CalOptima policies.

2.6.6. Hospital shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site concurrent reviews of the medical records of Members. CalOptima staff shall notify Hospital's utilization management department prior to conducting such on site reviews, shall wear appropriate identification, and shall schedule at times reasonable for Hospital.

2.7. Transfer of Care. Upon request by a CalOptima Member, Hospital shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Hospital shall make available to the new Provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.8. CCS Eligible Services. If Hospital is not a CCS paneled hospital authorized by CCS to provide the specific CCS-eligible Services required by Members, Hospital agrees to cooperate with CalOptima in the transfer of Members with CCS eligible conditions to an appropriately authorized CCS paneled Hospital.

2.9. Eligibility. Hospital shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services, and at the beginning of each calendar month thereafter during the continued provision of such services.

2.10. Medi-Cal Member Retroactive Eligibility. For Hospital Services provided to Members whose eligibility in Medi-Cal has been determined retroactively, Hospital agrees to the following:

2.10.1. To verify eligibility of Medi-Cal Members through the State of California's Beneficiary Eligibility Verification system and to report such eligible Members to CalOptima within forty-eight (48) hours of the Hospital becoming aware of Member's eligibility and enrollment in CalOptima.

2.10.2. Except for Emergency Services, Hospital's failure to notify CalOptima within forty-eight (48) hours of becoming aware of a Medi-Cal Member's eligibility may result in non-payment for services rendered.

2.10.3. The admission and length of stay of the Member shall be subject to retrospective review for Medical Necessity.

2.10.4. To submit complete Medical Records with all submitted claims.

2.11. Changes in Capacity. Hospital shall provide at least ninety (90) days' prior written notice to CalOptima of any significant changes in the capacity of Hospital or its Hospital Providers to furnish Hospital Services to Members. Hospital shall use reasonable efforts to eliminate or remedy any condition that results in a significant adverse change in capacity including (i) Hospital's inability to properly serve Members due to a lack of beds or other services or (ii) closure of any facility or service unit used by Hospital or its Providers.

2.12. Licensure/Certification of Employees. Each of Hospital's employees furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

2.13. Licensure. Hospital shall be and remain during the period of this Contract duly licensed by the State of California as a general acute care hospital. Hospital is currently in good standing, and at all times during the term of this Contract shall maintain good standing with the following:

2.13.1. all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

2.13.2. certification under Medicaid and Medicare; and

2.13.3. accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

2.14. Regulatory Approvals. Hospital represents and attests that it has, and shall maintain during the term of this Contract, applicable enrollment in the Medi-Cal and Medicare Programs and maintains National Provider Identifiers (NPIs).

2.15. Good Standing. Hospital represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG").

2.16. Notices and Citations. Hospital shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Hospital that contains a citation, sanction and/or disapproval of Hospital's failure to meet

any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.17. Professional Standards. All Hospital Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.18. Marketing Requirements. Hospital shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.19. Identification of Hospital. Hospital agrees that CalOptima may list the name, address, and telephone number of Hospital and a description of Hospital's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Hospital and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party. Except as provided in this paragraph, CalOptima may not use Hospital's name for marketing or advertising purposes without prior written permission from Hospital.

2.20. Disclosure of Hospital Ownership. Hospital shall provide CalOptima with the following information, as applicable: (a) names of all officers of Hospital's governing board; (b) names of all owners of Hospital; (c) names of stockholders owning more than five percent (5%) of the stock issued by Hospital; and (d) names of major creditors holding more than five percent (5%) of the debt of Hospital. Hospital shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Hospital shall notify CalOptima immediately of any changes to the information included by Hospital in the disclosure forms submitted to CalOptima.

2.21. Clinical Laboratory Improvement Amendments. Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.22. Admissions to Long Term Care Facility. Hospital shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Hospital shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long long-term care, Hospital shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

2.23. Newborn Services. For services provided to a child of a Member during the month of birth or the following month, Hospital shall bill for such services in accordance with the claim form completion instructions in the appropriate Medi-Cal Provider Manual relative to newborns.

2.24. Advance Directives. Hospital shall maintain written policies and procedures related to Advanced Directives in compliance with State and other applicable law. Hospital shall document patient records with respect to the existence of an Advance Directive in accordance with applicable law. Hospital shall not discriminate against any Member on the basis of that Member's Advance Directive status.

2.25. CalOptima QMI Program. Hospital acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Hospital. Hospital agrees, when reasonable and within capability of Hospital, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Hospital shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Hospital shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Hospital Services (*e.g.*, medical necessity) and shall accept as final all decisions regarding disputes over Hospital Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

2.26. Hospital Quality Improvement Program. Hospital shall establish, maintain and operate a quality improvement program, which shall include an annual quality improvement work plan and an annual performance evaluation of such work plan, which is consistent with current industry standards, Quality Improvement System for Managed Care (QISMC), NCQA, Leapfrog, and/or JCAHO.

Hospital shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.27. CalOptima Oversight. Hospital understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Hospital under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Hospital's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Hospital's performance of duties described in this Contract; (iii) require Hospital to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Hospital fails to meet CalOptima standards in the

performance of that duty. Hospital shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Hospital or the oversight of those duties.

2.28. Linguistic and Cultural Sensitivity Services. Hospital shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Hospital shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Hospital shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Hospital shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Hospital.

2.29. Provision of Interpreters. Hospital shall comply with Health and Safety Code Section 1259. To the extent that a CalOptima Member requires interpreter services beyond those mandated by that Health and Safety Codes Section, and to the extent that Hospital does not choose to provide such services, Hospital shall ensure that CalOptima is notified that the Member requires additional interpreter services, and CalOptima shall provide such services at its own expense. Interpreter services under this Section include both linguistic interpreter services and interpreter services for the deaf and hard of hearing, as may be necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements contained in this Contract and CalOptima Policies. Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Hospital shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available through CalOptima at no cost to the Member. Hospital may utilize interpreter services provided through the Cultural and Linguistic Coordinator within CalOptima's customer service department, as appropriate, at no charge to Hospital.

2.30. CalOptima's Compliance Program and Other Guidance. Hospital and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Hospital's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Hospital and Hospital shall make them available to Hospital's Agents. Hospital agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins,

which provide changes, updates and clarifications regarding CalOptima financial policies and contract interpretations.

CalOptima intends to amend its Compliance Plan and Code of Conduct to allow for the substitution of provider compliance plans and codes of conduct for CalOptima's Compliance Plan and Code of Conduct. Provided that such substitution is approved by the Government Agencies, then, upon approval by CalOptima's Compliance Department, Hospital's Compliance Plan and Code of Conduct may be substituted for the CalOptima Compliance Plan and Code of Conduct under this Contract.

2.31. Equal Opportunity. Hospital and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Hospital and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Hospital and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Hospital and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Hospital and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Hospital and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Hospital and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Hospital and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Hospital and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as

amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Hospital and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Hospital and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Hospital and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Hospital and its Subcontractors will include the provisions of this Section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Hospital and its Subcontractors will take such action with respect to any Subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Hospital and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, Hospital and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.32. Compliance with Applicable Laws. Hospital shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Hospital's performance under this Contract. Hospital shall comply with applicable terms and conditions of the contracts between CalOptima and Government Agencies. In accordance with the California Public Records Act, CalOptima shall provide copies of its contracts with the Government Agencies upon request. Hospital understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Hospital is are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Hospital agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.

2.33. No Discrimination/Harassment (Employees). During the performance of this Contract, Hospital shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Hospital shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Hospital shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.34. No Discrimination (Member). Hospital shall not discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary

discrimination); section 1557 of the Patient Protection and Affordable Care Act, and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Hospital agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Hospital shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Hospital shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.35. Nondiscrimination—Member Visits. Hospital shall ensure that it permits a Member, at Member's choice, to be visited by the Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children, in the same manner and to the same extent permitted for a Member's spouse or spouse's children, or the spouse of a Member's children or parents. Hospital shall include the language of this Section in any Subcontract for inpatient facility services.

2.36. Reporting Obligations. In addition to any other reporting obligations under this Contract, Hospital shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima. CalOptima shall reimburse Hospital for reasonable costs for producing and delivering such reports and data.

2.37. Subcontract Requirements. If permitted by the terms of this Contract, Hospital may subcontract for certain functions covered by this Contract, subject t o the requirements of this Contract. Subcontracts shall not terminate the legal liability of Hospital under this Contract. Hospital must ensure that all Subcontracts are in writing and include any and

all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Hospital shall make all Subcontracts available to CalOptima or its regulators upon request. Hospital is required to inform CalOptima of the name and business addresses of all Subcontractors. Hospital shall ensure that all Subcontractors providing services under this Contract to CalOptima Members comply with all applicable provisions of state and federal laws, regulations and program guidance when providing Covered Services to Members under this Contract. Additionally, Hospital shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.37.1. An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Hospital available at all reasonable times for inspection, examination or copying by CalOptima, Department of Health Care Services, Department of Health and Human Services and Department of Justice.

2.37.2. An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; and (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.38. Hospital Agreement to Extend Terms and Rates. Hospital agrees to extend to CalOptima Health Networks the same terms regarding Hospital performance, duties and obligations and rates for Hospital Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract.

2.39. Fraud and Abuse Reporting. To the extent required by and in compliance with CMS or other applicable federal and state laws, Hospital shall report to CalOptima all cases of suspected fraud and/or abuse related to rendering services provided under this contract to CalOptima members.

2.40. Participation Status. Hospital shall have Policies and Procedures to verify the Participation Status of Hospital's Practitioners. In addition, Hospital attests and agrees as follows:

2.40.1. Hospital and Hospital's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.40.2. Hospital shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Hospital or Hospital's Practitioners occurring and/or discovered during the term of this Contract.

2.40.3. Hospital shall take immediate action to remove any employee of Hospital that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima

Members which may include but not limited to adverse decisions and licensure issues.

2.40.4. Hospital shall include the obligations of this Section in its Subcontracts.

2.40.5. CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Hospital shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.41. Ethical and Religious Directives. Nothing in this Contract shall require Hospital to provide any services which would violate Hospital's Ethical and Religious Directives. Such services would include, but not be limited to, abortions not necessary to remedy a life-threatening condition of the mother, sterilizations not approved by Hospital guidelines, and euthanasia.

2.42. Tax Exempt Status. If Hospital is a tax-exempt entity, and at any time has a good faith reason to believe that this Agreement may jeopardize the tax-exempt status of Hospital, or any of its affiliates, under Section 501(c)(3) of the Internal Revenue Code and the ability of Hospital or any of its affiliates to obtain or maintain tax-exempt financing, the parties agree to amend this Agreement to the extent necessary to address such issues. Any such amendment shall attempt to preserve the parties' economic benefits of this Agreement to the greatest extent possible. In the event Hospital is advised by independent counsel in a written opinion that amendment of this Agreement will not be sufficient to address such issues, Hospital may terminate this Agreement as provided in Section 7.8 herein.

2.43. Physical Access for Members. Hospital shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.44. Smoke Free Workplace. To the extent Hospital facilities are accessible to Members, Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary

penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Hospital certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

2.45. Member Rights. Hospital shall ensure that each Member's rights, as set forth in state and federal law as applicable to CalOptima's programs in this Contract, are fully respected and observed.

2.46. Whole Child Model Program Compliance. If Hospital is a CCS authorized facility, then in the provision of CCS services to CalOptima Members, the Hospital shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Hospital will use evidence -based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.47. CCS Provider Compliance.

2.47.1. Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.47.2. If Hospital is a CCS-Paneled Provider, Hospital agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.47.2.1. Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Hospital shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.47.2.2. To ensure consistency in the provision of CCS Covered Services, Hospital shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Hospital shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.48. Government Claims Act. Hospital shall ensure that Hospital and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.49. Certification of Document and Data Submissions. All data, information, and documentation provided by Hospital to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required

by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Hospital's letterhead sign by the Hospital's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.50. Data Sharing Technology for Discharge Planning. Subject to compliance with all applicable laws and regulations, as well as all provisions of this Contract, Hospital agrees to evaluate and implement the use of data sharing technology for purposes set forth in California Health and Safety Code Section 1262.5, subdivisions (n)(4)(A) and (p), with respect to Members who are homeless patients, as defined in Health and Safety Code Section 1262.4.

ARTICLE 3

FUNCTIONS AND DUTIES OF CALOPTIMA

3.1. Payment. CalOptima shall pay Hospital for Hospital Services provided to CalOptima Members. Hospital agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Hospital Services. Upon submission of a Clean Claim, CalOptima shall pay Hospital pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Hospital may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

3.2. Service Authorization. CalOptima shall provide a written authorization process for Hospital Services pursuant to CalOptima Policies.

3.3. CalOptima Guidance. CalOptima shall make available to Hospital, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Hospital Services under this Contract.

3.4. Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Hospital any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments. CalOptima shall notify Hospital within two business days upon discovery of a payment issue related to this Section.

3.5. Identification Cards. CalOptima shall provide Members with identification cards indentifying Members as being enrolled in the applicable CalOptima program.

3.6. Care Management. CalOptima shall provide Care Management Services for Members through its Care Coordination Department.

3.7. Member Materials. CalOptima shall furnish Hospital any written materials that CalOptima wishes Hospital to provide to Members, including translations into threshold languages and at appropriate grade level, as appropriate.

ARTICLE 4
PAYMENT PROCEDURES

4.1. Billing and Claims Submission. Hospital shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2. Prompt Payment. CalOptima shall make payments to Hospital in the time and manner set forth in CalOptima Policies related to the CalOptima Programs. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3. Claim Completion and Accuracy. Hospital shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms, tape or electronically including claims submitted for the Hospital by other parties. Use of a billing agent does not abrogate Hospital's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Hospital acknowledges that Hospital remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Hospital notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5. COB. Hospital shall coordinate benefits with other programs or entitlements recognizing where other OHC is primary coverage in accordance with CalOptima Program requirements. Hospital acknowledges that Medi-Cal is the payor of last resort.

4.6. Member Financial Protections. Hospital and its Subcontractors shall comply with Member financial protections as follows:

4.6.1 Hospital agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Hospital for any amounts which are owed by, or are the obligation of, CalOptima. Hospital agrees that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

4.6.2 In no event, including but not limited to nonpayment by CalOptima, CalOptima's or the Hospital's insolvency, or breach of this Contract by CalOptima, shall the Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on the behalf of a Member, or against the State of California, for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Hospital may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.6.3 This provision does not prohibit Hospital from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.6.4 Upon receiving notice of Hospital invoicing or balance billing a Member for the difference between the Hospital's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Hospital or take other action as provided in this Contract.

4.6.5 This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members.

4.7. Overpayments and CalOptima Right to Recover. Hospital has an obligation to report any overpayment identified by Hospital, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Hospital, or of receipt of notice of an overpayment identified by CalOptima. Hospital acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Hospital, CalOptima shall have the right to recover such amounts from Hospital by recoupment or offset from current or future amounts due from CalOptima to Hospital, after giving Hospital notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Hospital to CalOptima, including, but not limited to, amounts due because of:

4.7.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

4.7.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

4.7.3 Unpaid Conlan reimbursements owed by Hospital to a Member.

4.7.4 Payments made for services provided by a Hospital that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1. Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out the negligent or willful performance or non-performance by the indemnifying party, or any

functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2. Insurance Requirements.

Professional/Medical Malpractice:
Hospital providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy with minimum limits as follows:

Hospital providing Covered Services:	$5,000,000 per incident/$5,000,000 aggregate

Commercial General Liability/Commercial Automobile Liability:
Each Hospital providing Covered Services to Members shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:	$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:	$1,000,000 per occurrence/$3,000,000 aggregate

Workers' Compensation:
Hospital providing Covered Services to Members shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:	$1,000,000 Bodily injury each accident $1,000,000 Bodily injury policy limit $1,000,000 Bodily injury each employee

5.3. Insurance Requirements (continued). Hospital, at their sole cost and expense, shall maintain the above referenced policies as shall be necessary to insure themselves, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of: (a) personal injuries or death occasioned in connection with the performance of any Covered Services provided hereunder; (b) the use of any property and Facilities of the Hospital; and (c) activities performed in connection with the Contract.

5.4. Insurer Ratings. Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

5.5. Captive Risk Retention Group/Self Insured. Where any of the Insurance(s) mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.4 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.Cancellation or Material Change. The FFS Hospital shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.Proof of Insurance. Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1. Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Hospital shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Hospital's premises. Hospital shall be given advance notice of such visit in accordance with state and federal law, and CalOptima Policies. Such access shall include the right at all reasonable times to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract and inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Hospital shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. Hospital shall also comply with any audit and access requirements set forth in the CalOptima Program Addenda, as applicable. All inspections and evaluations shall be performed in such a manner as will not unduly delay the services. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Hospital at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Hospital from participation in the Medi-Cal program; seek recovery of payments made to the Hospital; impose other sanctions provided under the State Plan, and Hospital's contract may be terminated due to fraud.

6.2. Medical Records. Hospital shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction

of, the Hospital. Such medical records shall be in such a form as to allow trained health professionals, other than the Hospital, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3. Records Retention. The Hospital shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Hospital furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4. Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. CalOptima shall pay all duplication and mailing costs associated with such audits if costs exceed $50 per request.

6.5. Confidentiality of Member Information. Hospital agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Hospital further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Hospital shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Hospital shall comply with HIPAA requirements, other obligations imposed by Regulatory Agencies, and state laws applicable to the confidentiality of patient medical information. Hospital shall also support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Hospital shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Hospital and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Hospital and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6. Data Submission. Hospital shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1. Term. The term of this Contract shall become effective on the Effective Date and shall remain in effect up to and including June 30, 2020. This Contract shall automatically extend for additional one-year terms upon formal approval by the CalOptima Board of Directors, unless terminated by either party as provided for in this Contract.

7.2. Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Hospital (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Hospital prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Hospital shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Hospital.

7.3. Termination for Non-Payment. Hospital may terminate if CalOptima stops making all payments to Hospital for Hospital Services. In the event of a termination for Non-Payment, Hospital shall give CalOptima prior written notice of its intent with a thirty (30) day cure period. In the event the Non-Payment is not cured within the thirty (30) day cure period, Hospital may terminate the Contract immediately following such thirty (30) day period.

7.4. Hospital's Appeal Rights. Hospital may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Hospital's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.5. Immediate Termination**.** CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Hospital and/or Hospital Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Hospital or against Hospital Agents in their capacities with the Hospital by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Hospital.

7.6. Termination for Insolvency. If either party becomes insolvent, their obligation is to immediately notify the other party. The other party at its sole option, will have the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against either party, that party shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.7. Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Hospital in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Hospital shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.8. Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.9. Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, changes in Covered Services and/or by CalOptima Board actions. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Hospital. Notwithstanding any other provision of this Contract, in the event of a rate adjustment under this Section, Hospital shall have the right, within thirty

(30) days of receipt of notice of rate adjustment, to terminate this Contract by providing CalOptima with thirty (30) days written notice of such termination.

7.10. Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Hospital shall continue to provide authorized Hospital Services to Members who retain eligibility and who are under the care of Hospital at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Hospital shall continue to provide Hospital Services to hospitalized Members in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from Hospital; or alternate coverage is arranged for by CalOptima. Payment for any continued Hospital Services as described in this Section shall be at the contracted rates set forth in Attachment B. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Hospital shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Hospital necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable.

7.11. Approval by and Notice to Government Agencies. Hospital acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima, and to the extent that this contract includes the provision of services to Medi-Cal beneficiaries, Hospital shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program after CalOptima provides notification of the name of the officer. Hospital acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1. Hospital Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Hospital, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Hospital complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2. Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Hospital agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1. Assignment and Assumption. Hospital acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Hospital have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Hospital, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Hospital, (c) the merger, reorganization, or consolidation of Hospital with another entity with respect to which Hospital is not the surviving entity, and/or (d) a change in the management of Hospital from management by persons appointed, elected or otherwise selected by the governing body of Hospital (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2. Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Hospital and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3. Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4. Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima. Hospital shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

9.5. Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6. Independent Contractor Relationship. CalOptima and Hospital agree that the Hospital and any agents or employees of the Hospital in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Hospital's

relationship with CalOptima in the performance of this Contract is that of an independent contractor. Hospital's personnel performing services under this Contract shall be at all times under Hospital's exclusive direction and control and shall be employees of Hospital and not employees of CalOptima. Hospital shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7. No Liability of County of Orange, State of California. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Hospital hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

9.8. No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9. Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party's address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Chief Operating Officer
505 City Parkway West
Orange, CA 92868

If to Hospital:

_____
Name

_____
Title

_____
Address

_____

9.10. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11. Prohibited Interests. Hospital covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12. Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of the terms and conditions of this Contract, amendments thereto, and assignments thereof, are subject to the approval of applicable Governmental Agencies and the conditions imposed by such Agencies. In the event that the Government Agencies disapprove any provision of this Contract, or impose any condition not otherwise provided for in this Contract (an "Adverse Action"), Parties shall in good faith negotiate an amendment to this Contract necessary or appropriate to resolve the Adverse Action. If after thirty (30) calendar days the parties are unable to agree on an amendment necessary or appropriate to resolve the Adverse Action, then the Contract shall terminate. The terms of this Agreement shall be binding until amended or the Agreement terminates.

9.13. Authority to Execute. The persons executing this Contract on behalf of the parties attest that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14. Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1. This Contract is further subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and the execution of the Government Contracts and the approval of the Contract by the Government Agencies.

10.2. This Contract shall become effective on July 1st, 2019 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Hospital	CalOptima
_____ Signature _____ Print Name _____ Title _____ Date	_____ Signature _____ Print Name _____ Title _____ Date

ATTACHMENT A

HOSPITAL SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1. CalOptima Programs. Hospital shall furnish covered services to eligible members in the following CalOptima Programs:

___X___ Medi-Cal Program
___X___ OneCare Program
___X___ Cal MediConnect Program/OneCare Connect
___X___ PACE Program

ARTICLE 2
HOSPITAL SERVICES

2.1. Hospital is responsible for providing all covered Hospital Services, as authorized by CalOptima or designee, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary, including but not limited to:

1. Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2. Hospitalization in an intensive care unit or special care unit;
3. Pediatric services;
4. Maternity services;
5. Psychiatric and substance abuse services;
6. Newborn nursery, all levels;
7. Ancillary services and supplies, including laboratory and radiology services;
8. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
9. Emergency Department Services (as provided in Section 2.3 of this Contract, Emergency Services do not require prior authorization);
10. Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s); and
11. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

"Hospital Services" does not include bone marrow or solid organ transplantation or home-administered blood clotting factors for the treatment of hemophilia.

ATTACHMENT B

COMPENSATION

For Covered Services provided to CalOptima Medi-Cal Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Outpatient Services

Outpatient services shall be reimbursed at XXX of Medi-Cal reimbursement rates. Outpatient services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient Services

All inpatient facility services shall be paid at XXX of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four hours of an emergency department visit. Inpatient rates are all inclusive. High cost exclusion items will not be reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient admissions to the Hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of stay.

II. Medicare Advantage (OneCare)

I. INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

==========

Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX -current Medicare, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc.). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital's Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.

d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. Cal MediConnect (OneCare Connect)

I. INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

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Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima Cal MediConnect Enrollees, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX of Hospital's then-current Medicare Program Rate as though Medicare was the payer, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital's Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.
d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

IV. PACE

INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

==========

Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima PACE members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX of Hospital's then-current Medicare Program Rate as though Medicare was the payer, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital's Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.
d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

ATTACHMENT B-1

MEDI-CAL COMPENSATION RATES FOR ADULT EXPANSION MEMBERS

Compensation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will amend the Contract to adjust payments made to the Hospital.

For Covered Services provided to CalOptima Medi-Cal Adult Expansion Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Outpatient Services

Outpatient services shall be reimbursed at XXX of Medi-Cal reimbursement rates. Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient Services

All inpatient facility services shall be paid at XXX of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. High cost exclusion items will not be reimbursable. Billing must comply with Medi-Cal guidelines.

All inpatient services must be authorized. Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

ATTACHMENT C

DISCLOSURE FORM

_____
Name of Hospital

The undersigned hereby certifies that the following information regarding

_____ (the "Hospital") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Hospital's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Hospital's debt:

_____

_____

Form of Hospital (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital shall maintain and retain all records of all items and services provided to Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Hospital's books and records shall be maintained within or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Hospital's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Hospital shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of Contract, available for purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at the Hospital's place of business or such other mutually agreeable location in California, and (c) in a form maintained in accordance with general standards applicable to such book or record keeping, for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Hospital shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Hospital shall cooperate in the audit process by signing any consent forms or documents required by but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Hospital may possess in order to verify Hospital's records.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise

3. Form of Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Part Tort Liability/Estate Recovery. [State Contract, Ex. E, Att 2 § 22] Hospital shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation. [State Contract, Ex. A, Att. 6, § 12(B)(15), Ex. E, Att. 2, § 23]

5.1. Upon request by CalOptima, Hospital shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Hospital or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

5.2. In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Hospital for complying with Paragraph 5.1, above, as follows:

5.2.1. CalOptima shall reimburse Hospital amounts paid by Hospital to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Hospital with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Hospital to any third party for assisting Hospital in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2. If Hospital uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Hospital as specified below. Hospital shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1. Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2. Costs for copies of all documentation submitted to CalOptima pursuant to paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3. Hospital shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Hospital under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. [State Contract, Ex. A, Att. 4, § 13] All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Hospital shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider site.

7. Downstream Contracts. [State Contract, Ex. A, Att. 6, § 12(B)(9)] In the event that Hospital is allowed to subcontract for services under this Contract, and does so subcontract, then Hospital shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS.

8. (This section left intentionally blank).

9. Changes in Availability or Location of Services. [State Contract, Ex. A, Att. 9, § 9] Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Hospital's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. [State Contract, Ex. D(F) § 13; Ex. E, Att. 2, § 19] Hospital and its employees, or agents shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Hospital, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Hospital and its employees, or agents shall not use such identifying information for any purpose other than carrying out Hospital's obligations under this Contract.

Hospital and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Hospital shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Hospital from unauthorized disclosure. Hospital may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Hospital, Hospital:

10.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

10.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

10.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

10.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Hospital by CalOptima for this purpose.

11. Debarment Certification. [State Contract, Ex. D(F), § 19] By signing this Contract, the Hospital agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

11.1. By signing this Contract, the Hospital certifies to the best of its knowledge and belief, that it and its principals:

11.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

11.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission

of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 11.1.2 herein; and

11.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

11.1.5. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

11.1.6. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

11.2. If the Hospital is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to CalOptima.

11.3. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

11.4. If the Hospital knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. [State Contract, Ex. E, Att. 2, § 15] If required by DHCS, Hospital shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. [State Contract, Ex. D(F), § 11] Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Hospital agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Lobbying Restrictions and Disclosure Certification. [State Contract, Ex. D(F), § 31]

14.1. (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2. Certification and Disclosure Requirements

14.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 14.3 of this provision.

14.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

14.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

14.2.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.2.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.2.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.3. Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements. [State Contract, Ex. A, §12(B)(11)]

15.1. Hospital shall ensure that all Subcontracts are in writing and require that the Hospital and its Subcontractors:

15.1.1. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2. Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

15.2. Hospital shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1. Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2. Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

15.2.3. An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15.2.4. An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.5. An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.36 and 6.6 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 and 22 of this Addendum 1.

15.2.6. An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.7. An agreement to maintain and make available to DHCS, CalOptima, and/or Hospital, upon request, all sub-subcontracts related to the Subcontract, and eto ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.8. An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 17 of this Addendum 1.

15.2.9. An agreement to assist Hospital and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.10. An agreement to hold harmless the State, Members, and CalOptima in the event the Hospital cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.6 of the Contract.

15.2.11. An agreement to notify DHCS in the manner provided in Section 7.11 of the Contract in the event the Subcontract is amended or terminated.

15.2.12. An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.29 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.28 or the Contract.

15.2.13. Subcontractor shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal members, as provided in CalOptima Policies relative to the Medi-Cal Program, and excluding any contract

disputes between Hospital and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

15.2.14. An agreement to participate and cooperate in quality improvement system as set forth in Section 2.25 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Hospital determines that the Subcontractor has not performed satisfactorily.

15.2.15. If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.16. An agreement by the Hospital to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.7. of the Contract.

15.2.17. An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.18. An agreement that Subcontractors shall notify Hospital of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

16. State's Right to Monitor. Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Hospital's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Hospital, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Hospital. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by authorized State agencies will have access to all security areas and the Hospital will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Hospital and/or the subcontractor(s).

17. Hospital shall comply with all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

18. Hospital shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Hospital shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

21. Hospital agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Hospital of Subcontractor; (iii) the merger, reorganization, or consolidation of Hospital or Subcontractor, with another entity with respect to which Hospital or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Hospital or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Hospital or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Hospital further agrees to timely gather, preserve, and provide to DHCS any records in the Hospital's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

23. Hospital agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Hospital shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Hospital is responsible for the coordination of care for Members, CalOptima shall share with Hospital, in accordance with the appropriate Declaration of Confidentiality signed by Hospital and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Hospital shall receive the utilization data provided by CalOptima and use it as the Hospital is able for the purpose of Members care coordination.

26. Hospital shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by the Hospital pursuant to the Contract.

Addendum 1--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 1--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Hospital agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later unless a longer time is required under MA regulations.

2. Right of Inspection, Evaluation, Audit of Records. Hospital and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Hospital's provision of health care services to Members, the cost of such services, and payments received by Hospital from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Hospital further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Hospital pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

    3.1. Delegation by CalOptima. Hospital warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Hospital agrees to perform the delegated activities in a manner consistent with the delegation criteria. Hospital agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Hospital acknowledges that delegation to another entity does not alter Hospital's ultimate obligations and responsibilities set forth in this Contract. Hospital acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly

delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

3.2. Reports on Delegated Activities. Hospital agrees to provide CalOptima with periodic reports on delegated activities performed by Hospital as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Hospital agrees to take those corrective actions identified by CalOptima through the audit review process.

3.3. CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Hospital, which will be monitored by CalOptima on an ongoing basis. In the event Hospital breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Hospital as set forth in this Contract. Moreover, CalOptima shall have the right to require Hospital to terminate any Subcontracting Hospital for good cause, including but not limited to breach of its obligations to perform any delegated duties.

3.4. Review of Credentials. Hospital shall ensure that the credentials of medical professionals affiliated with the Hospital are reviewed by it. Hospital agrees that CalOptima will review and approve Hospital's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Hospital agrees to comply with MSP requirements. Hospital shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Hospital agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Hospital will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Hospital Authority to Bill Third Party Payers. Hospital may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Hospital Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Hospital may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under Section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the

extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Hospital shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Hospital also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Hospital agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 92 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Hospital bills a third party payor as primary. Hospital agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Hospital within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Hospital, or, CalOptima will contest or deny Hospital's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. Provider Terminations. In the event a provider intending to become a Participating Provider is denied medical staff privileges at the Hospital or a Participating Provider is suspended or removed from the medical staff, Hospital shall provide the provider with written notice of the reason for the action as required by Federal and State laws. In the event Hospital terminates a Participating Provider's medical staff membership for deficiencies in the quality of care provided, Hospital shall give notice of the action to the appropriate licensing and disciplinary agencies.

8. Prohibited Interference With Enrollment Relationships. Hospital agrees that it will not: (a) violate any laws and regulations governing the solicitation of CalOptima Enrollees; (b) encourage or seek to have an Enrollee disenroll from CalOptima and/or enroll in (i) another health maintenance organization, including one in which Hospital has an ownership interest, (ii) another managed care plan, (iii) a case management arrangement, or (iv) any other similar arrangement, including any other arrangement in which Hospital has a direct or indirect ownership interest (collectively referred to as "Alternative Care Plan"); and/or (c) interfere with the enrollment of CalOptima Enrollees. Any such activity would constitute a material breach of this contract. The provisions of this Section shall apply to all Hospital employees and subsidiaries and affiliates of Hospital, including any such arrangements established after the Effective Date of this Contract. Nothing in this Section shall prohibit Hospital from providing information to the public as to its affiliation with an Alternative Care Plan, so long as such activities do not include any of the prohibited activities set forth above. Both parties agree that if a dispute arises as to whether there has been a breach of this Section it shall be resolved in accordance with the dispute resolution section of this Agreement, set forth in Article XIII.

9. Medical Decision-Making. It is not the intention of CalOptima to use the preauthorization and approval provisions set forth herein as a device by which it may practice medicine. Rather, the authorization and approval procedures are used to make benefit and coverage determinations so that the Member and Participating Providers know, before a course of treatment is initiated, that such course of treatment is covered in full, in part or not at all. If a course of treatment is not covered, *e.g.*, not approved, such determination is not intended to suggest that the course of treatment is medically inappropriate. CalOptima will notify the attending Physician (Specialist Physician) and, if applicable; the primary care physician, of a denial of coverage; however, Physicians and/or Hospital may choose to provide such course of treatment, so long as prior written notice is given to the Member that the course of treatment is not covered by CalOptima. Hospital may bill a Member for Non-Covered Services, but may not bill a Member for Covered Services which are not Medically Necessary.

10. Retroactive Denials of Payment and Recoupment. When CalOptima is notified of retroactive disenrollments of Members, or when CalOptima obtains information or data that contradicts its reliance that caused its authorization for Hospital Services, CalOptima may retroactively deny Hospital Services furnished to Members, and shall send immediate written notice of such denial to Hospital. Hospital shall recognize CalOptima's immediate right to recovery for retroactively disenrolled Members who were disenrolled no earlier than thirty (30) days prior to the date of service at the Hospital, and shall refund contested paid claims within forty-five (45) working days of notice from CalOptima. CalOptima may recoup, per CalOptima policy, any such amounts in the event that Hospital does not repay such amounts as provided above. Other than as provided for above, should the Hospital follow correct CalOptima authorization procedures, and Hospital receives an authorization from CalOptima to provide Hospital Services to a Member, CalOptima shall be liable to reimburse Hospital per the terms and conditions of this Contract. Under no circumstances shall payment be denied for such previously authorized services based on retroactive Medical Necessity determinations. This clause shall not be construed to limit CalOptima's right to recoup payments made to the Hospital on any other basis for which recoupment is appropriate.

11. Use of Hospital Name. CalOptima may use Hospital's name for advertising/marketing purposes, but may not use Hospital's trademarks or logos without prior written permission.

ADDENDUM 3

CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Hospital shall provide services or perform other activity pursuant in the Contract in accordance with (i) applicable DHCS and CMS laws, regulations and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS, .

2. Hospital shall (i) safeguard Enrollee privacy and confidentiality of Enrollee (ii) comply with all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Enrollees to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.

3. The performance of the Hospital and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Hospital shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

4. Hospital shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.

5. Hospital shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6. Hospital acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with Hospital actions required to comply with EMTALA.

7. Hospital shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Hospital shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Hospital shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual

differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Hospital shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

8. Hospital shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.

9. Hospital shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Hospital. Hospital may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Hospital is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Hospital for the provision of covered services under the CalOptima Cal MediConnect Program solely because Hospital has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1. If any services under this Contract are to be provided by a Downstream Entity on behalf of Hospital, Hospital shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, , 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

11.1.1. An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 2.32 of the Contract.

11.1.2. An agreement to (i) Enrollee financial protections in accordance with Section 4.6 of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Hospital, and (ii) safeguard Enrollee privacy and confidentiality of Enrollee health records.

11.1.3. An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4. An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 2.27 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5. If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6. An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2. In addition to Section 11.1 of this Addendum 3, Hospital shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1. Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Hospital.

11.2.2. An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3. An agreement that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4. An agreement to comply with (i) the confidentiality requirements of Enrollee records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5. An agreement that (i) providers shall not close or otherwise limit their acceptance of Enrollees as patients unless the same limitations apply to all

commercially insured enrollees, and (ii) Enrollees shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.6.1 of the Contract and Section 20 of this Addendum.

11.2.6. An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7. An agreement that the medical provider assist the Hospital and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8. An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.11 of the Contract in the event the subcontract is amended or terminated.

11.2.9. An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract.

11.2.10. An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.25 of the Contract, and (ii) the provision of interpreter services for Enrollees at all provider sites in accordance with Section 2.29 of the Contract.

12. Right of Inspection, Evaluation, and Audit of Records. Hospital and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Hospital's provision of health care services to Members, the cost of such services, and payments received by Hospital from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Hospital and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.27 of the Contract in instances where CMS, DHCS, and/or CalOptima

determines that the Hospital and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Hospital shall ensure that the credentials of medical professionals affiliated with the Hospital are reviewed by it. Hospital agrees that CalOptima will review, approve, and audit Hospital's credentialing process on ongoing basis.

15. Provider Terminations. In the event a provider intending to become a Participating Provider is denied medical staff privileges at the Hospital or a Participating Provider is suspended or removed from the medical staff, Hospital shall provide the provider with written notice of the reason for the action as required by Federal and State laws. In the event Hospital terminates a Participating Provider's medical staff membership for deficiencies in the quality of care provided, Hospital shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 2.7 of the Contract, Hospital agrees to assist CalOptima in the transfer of care of a Member. Hospital shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Hospital is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Hospital agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Hospital or Downstream Entity; (iii) the merger, reorganization, or consolidation of Hospital or Downstream Entity, with another entity with respect to which Hospital or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Hospital or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Hospital or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Hospital agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Hospital's or its Subcontractor's possession.

20. In addition to Section 4.6.1 of the Contract, Hospital acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Enrollees.

Addendum 3--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 3--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): b. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): b. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

16. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

17. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ADDENDUM 4
PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 4 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1. This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2. Amendments to this Contract and amendments to any subcontract agreements between Provider and subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3. CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees.
   Provider shall be accountable to CalOptima in accordance with the terms of this Contract.
   For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1. Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2. Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3. Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may

be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

2.6. Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

2.7. Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8. Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9. Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10. Provision of Direct Care Services to PACE Participants. Provider hereby represents and warrants that Provider and all employees of Provider providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Provider agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Provider or any employee of Provider providing services to CalOptima PACE participants no longer meets any of these requirements.

All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.10.1. Comply with any State or Federal requirements for direct patient care staff in their respective settings;
2.10.2. Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Provider furnishes;
2.10.3. Have verified current certifications or licenses for their respective positions;
2.10.4. Have not been excluded from participation in Medicare, Medicaid or Medi-Cal;
2.10.5. Have not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;
2.10.6. Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;
2.10.7. Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and
2.10.8. Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.11. The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not

be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

12.1.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

13. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

13.1. By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

13.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

13.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or

commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

13.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.1.2 herein; and

13.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

13.1.5. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

13.1.6. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

13.2. If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

13.3. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

13.4. If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

15. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

16. Lobbying Restrictions and Disclosure Certification.

16.1. (Applicable to federally funded contracts in excess of $100,000, per Section 1352 of the 31, U.S.C.)

16.2. Certification and Disclosure Requirements

16.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and

which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 16.3 of this provision.

16.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 16.3 of this provision if paid for with appropriated funds.

16.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure, or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

16.2.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

16.2.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

16.2.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

16.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

16.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

16.3. Prohibition—Section 1352 of Title 31, U.S.C., provides, in part, that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the

extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

17. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

Addendum 4--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than #100,000 for each failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 4--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): c. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): c. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

18. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

19. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

32. Authorize an Amendment Extending the Term of the Kaiser Foundation Health Plan, Inc. Health Maintenance Organization Health Network Contract and Current Rates, and Ratify the Delegation Agreement Related to that Contract

Contacts

Ladan Khamseh, Chief Operating Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions

1. Consider continuing the current alternative capitation rate methodology for Kaiser Foundation Health Plan, Inc. (Kaiser) through June 30, ~~2022~~ 2023;

2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend the Kaiser Medi-Cal, Full-Risk Health Maintenance Organization (HMO) contract to extend the term through June 30, ~~2022~~ 2023; and

3. Ratify the Delegation Agreement

Rev. 6/3/2021

Background

CalOptima's health care delivery system is largely delegated to the following twelve (12) contracted health networks that participate in CalOptima's Medi-Cal program. CalOptima also operates direct health networks, which include CalOptima Direct–Administrative (COD-A) and CalOptima Community Network (CCN). The Physician Hospital Consortia (PHC) and Health Maintenance Organization (HMO) Health Networks are fully delegated. Regardless of the Health Network model, all CalOptima members have access to all covered, medically necessary health care services.

Physician Hospital Consortia (PHC)	Health Maintenance Organization (HMO)	Shared Risk Group (SRG)
AMVI Care Health Network	Heritage Provider Network, Inc.	AltaMed Health Services Corporation
CHOC Physicians Network	Kaiser Foundation Health Plan, Inc.	ARTA Western California, Inc.
Family Choice Medical Group, Inc.	Monarch Health Plan, Inc.	Noble Community Medical Associates, Inc. of Mid-Orange County
	Prospect Health Plan, Inc.	Talbert Medical Group, P.C.
		United Care Medical Group, Inc.

Kaiser participates in CalOptima's Medi-Cal program as a delegated subcontractor under the HMO Health Network model. As with a number of other Health Networks, Kaiser has been part of

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CalOptima's provider network for over 20 years. It offers a full-service HMO network to what has grown to approximately 50,000 CalOptima members, or approximately 6% of CalOptima's total Medi-Cal membership. Each of CalOptima's contracts with its 12 Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments.

Upon expiration of CalOptima's HMO contract with Kaiser in June 2019, CalOptima staff presented Kaiser with an Amended and Restated Contract, along with five additional amendments over a period of almost two years. Unlike CalOptima's other Health Networks, Kaiser did not execute these documents. Since June 2019, the Board authorized short-term extensions of the previous contract on August 6, 2020, October 1, 2020, November 5, 2020, and December 3, 2020 to allow for a series of discussions regarding certain contract terms that Kaiser has been engaged in with CalOptima. On February 4, 2021, the Board authorized the current Amended and Restated Contract that was signed and is currently in place with Kaiser through the end of the current fiscal year.

Capitation Rate Methodology

CalOptima's capitation model is based on an industry standard method that factors in the acuity of assigned members, utilization from encounter data, current fee-for-service contract terms, and other factors to determine the appropriate rate for the membership risk assigned to the specific Health Network. Capitation base rates are periodically updated through what is known as "rebasing," with the goal being to develop rates that properly align capitation payments to a Health Network's level of delegated risk. To ensure that Health Networks are accurately and sufficiently compensated, rebasing is performed on a periodic basis to account for any material changes to medical costs and utilization patterns.

CalOptima had implemented rebased capitation rates for all health networks other than Kaiser ahead of the approval of the FY 2020-2021 budget. CalOptima updated the professional and hospital capitation rates for the Medi-Cal Classic population through this rebasing effort.

On February 4, 2021, the CalOptima Board authorized the execution of the Amended and Restated Contract and subsequent Amendments with Kaiser, which incorporated language changes and revisions to capitation rates, effective July 1, 2019 through June 30, 2021. CalOptima staff had numerous discussions with Kaiser in an effort to align Kaiser's rates with assigned membership risk based on established rebasing methodology. However, Kaiser believes that the current methodology is appropriate and supported by the scope of services provided by its network. The Board's action on February 4, 2021 resulted in a four month extension of that methodology through June 30, 2021.

Annual Contract Extension

The Kaiser Medi-Cal Full-Risk HMO health network is contracted with CalOptima to provide care to the Medi-Cal members that CalOptima assigns to Kaiser. The continued renewal of Kaiser's contract will support the stability of CalOptima's contracted provider network and ensure that CalOptima Medi-Cal members assigned to the Kaiser HMO health network continue to have access to covered health care services through Kaiser for the coming fiscal year without disruption.

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Delegation Agreement

The Delegation Agreement delineates delegated administrative services that the Health Networks are responsible for performing. This agreement is required for the National Committee for Quality Assurance (NCQA) accreditation, and under the terms of CalOptima's Medi-Cal contract with the Department of Health Care Services (DHCS). In order to meet the NCQA audit submission deadline, all of CalOptima's health networks were required to sign their respective Delegation Agreements no later than mid-May 2021. Staff has been engaged in discussions with Kaiser to ensure that the delegation agreement requirements for Kaiser are finalized within this time frame. Staff is now seeking Board ratification of this delegation agreement.

Discussion

CalOptima's health network contracts are renewed on an annual basis each July, subject to Board approval. For the upcoming FY 2021-2022, CalOptima staff has continued to work with Kaiser on the rebased capitation rates and methodology in an effort to align with the approach used for all the other health networks. Notwithstanding CalOptima's rebasing efforts, Kaiser's position remains that it is to continue to be paid under the current financial arrangement.

The percentage of premium arrangement is a carry-over from a prior arrangement when Kaiser was directly contracting with the Department of Health Care Services (DHCS) and CalOptima under a three-way contract arrangement, which ended in 2018. While Kaiser now contracts directly with CalOptima as a subcontractor, Kaiser has continued to receive payments based on a percent of the premium CalOptima receives from DHCS. DHCS's primary capitation rates to CalOptima are not calculated as a pass-through that flows directly to the health networks. These primary rates are for CalOptima's total Medi-Cal membership. Kaiser membership, which is limited to former Kaiser members, or those with a family link to a Kaiser member, has lower risk than the CalOptima average (inclusive of CCN complex members). Therefore, utilizing CalOptima's average rates are not consistent with the rates for Medi-Cal members assigned to Kaiser.

While the rate methodology discussions with Kaiser have not been completed, there is acknowledgment that Kaiser is a valued health network with high quality measures and member satisfaction levels, and innovative approaches to care. In addition, transitioning members to other Health Networks at this time, resulting in disruption of their care during the COVID-19 pandemic period, would not be in the best interest of the members CalOptima serves. CalOptima staff will continue to work toward achieving a rate methodology with Kaiser for future periods that is more consistent with the other health networks.

To presently ensure continued access to covered services for CalOptima members assigned to the Kaiser Health Network during the COVID-19 pandemic, and compliance with NCQA and DHCS requirements, continuing Kaiser's separate rate methodology, and approving the extension of Kaiser's Health Network contract through June 30, 2022, and ratifying the Delegation Agreement is recommended.

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Fiscal Impact

Management has assumed the continuation of the existing rate methodology for Kaiser and included expenses associated with the CalOptima Medi-Cal Full-Risk HMO contracts in the proposed CalOptima Fiscal Year (FY) 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will maintain and continue the contractual relationship with Kaiser as a valued health network within CalOptima's health care delivery system, ensure continued access to care for CalOptima's Kaiser members during the COVID-19 pandemic, and fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Kaiser Medi-Cal Full-Risk Contract for Health Care Services proposed amendment (template)
3. Delegation Agreement (Signed)
4. Kaiser Medi-Cal Full-Risk Contract for Health Care Services including subsequent amendments
5. Previous Board Action dated February 4, 2021: "Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

/s/ Richard Sanchez — *05/26/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to extend the term of the Contract and revise the capitation rates.

NOW, THEREFORE, the parties agree as follows:

1. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS AMENDED AND RESTATED CONTRACT SHALL BE JULY 1, 2019 THROUGH JUNE 30, 2022."

2. Attachment E shall be deleted in its entirety and replaced with the attached Attachment E – Amendment VI "Capitation Rates".

3. Attachment E-1 shall be deleted in its entirety and replaced with the attached Attachment E-1 – Amendment VI "Capitation Rates for Adult Expansion Members".

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME

	Chief Operating Officer
TITLE	TITLE
DATE	DATE

ATTACHMENT E – AMENDMENT VI
Capitation Rates

Effective July 1, 2021

ATTACHMENT E-1 – AMENDMENT VI
Capitation Rates for Adult Expansion Member

Effective July 1, 2021

DELEGATION ACKNOWLEDGEMENT AND ACCEPTANCE AGREEMENT FOR MEDI-CAL PROGRAM

Kaiser Foundation Health Plan, Inc. ("Delegate") agrees to perform the delegated services for CalOptima's Medi-Cal Program, in accordance with the responsibilities set forth in the attachment to this Delegation Acknowledgment and Acceptance Agreement ("Agreement"), with respect to CalOptima members assigned to the Delegate's network.

The purpose of the Delegation Grid, which is attached hereto and incorporated herein by reference, is to specify the activities delegated by CalOptima under the Agreement with respect to: (1) Quality Improvement, (2) Population Health Management, (3) Network Management, (4) Utilization Management, (5) Credentialing and Recredentialing, (6) Member Experience, (7) Claims, (8) Provider Complaint, and/or (9) Medicaid, as applicable. All delegated activities shall be performed in accordance with currently applicable NCQA accreditation standards, State and Federal statutory, regulatory, and sub-regulatory requirements, and CalOptima Policies and contractual requirements, including CalOptima's contract(s) with its regulator(s) and CalOptima's contract(s) with the Delegate, (collectively, "Standards and Requirements"), as modified from time to time. This agreement shall not be construed as limiting or circumscribing the Delegate's obligations to comply with all applicable Standards and Requirements when performing delegated activities for applicable CalOptima Program (s). Further, the Delegate shall comply with the most stringent applicable Standards and/or Requirements for such delegated activities.

Delegate agrees to be accountable for all responsibilities delegated by CalOptima and oversight of any sub-delegated functions or activities. CalOptima will maintain oversight of delegated activities to ensure compliance with applicable Standards and Requirements. Any sub-delegation by Delegate of the activities or functions set forth in this Agreement shall require prior written approval from CalOptima and shall comply with all terms and conditions of this Agreement, including but not limited to applicable Standards and Requirements. CalOptima retains the right to perform a pre-delegation audit of any entity to which the Delegate sub-delegates delegated functions or activities and approve any such sub-delegation audit. Prior to entering into an agreement to sub-delegate delegated activities, Delegate shall provide CalOptima with prior notice of Delegate's intent to sub-delegate in accordance with the Contract for Health Care Services between CalOptima and Delegate. The Delegate shall conduct risk assessments, at least annually, ongoing Monitoring, and Audit of sub-delegates to ensure compliance. CalOptima retains the right to conduct CalOptima's own risk assessments, ongoing Monitoring, and Audits of sub-delegate's performance of sub-delegated functions or activities.

Delegate agrees to submit reports, data, and documentation to CalOptima, as identified in the Delegation Grid and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Timely and Appropriate Submission Grid - Supplemental Attachment (collectively, "CalOptima Reporting Policy"). See CalOptima Reporting Policy for reporting descriptions and frequency, and manner of submission to applicable CalOptima Departments. CalOptima Reporting Policy may be modified from time to time pursuant to CalOptima Board approval. Delegate acknowledges it has additional reporting responsibilities and other obligations to CalOptima, as specified in applicable CalOptima Policies or contractual requirements (including the Contract for Health Care Services between CalOptima and the Delegate) that are not related to this Agreement.

CalOptima shall perform oversight, including Audit(s) and ongoing Monitoring, of the functions and responsibilities, processes, and performance of a delegated entity and its delegated services, in accordance with CalOptima Policies, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Failure by Delegate to comply with applicable Standards and/or Requirements may lead to further action, in accordance with CalOptima Policy HH.2005: Corrective Action Plan and CalOptima Policy HH.2002: Sanctions. CalOptima may amend or revoke any of the delegated responsibilities set forth in this Agreement.

For purposes of this Agreement, the term "Audit" or "Auditing" means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications. The term "Monitoring Activities" or "Monitoring" means regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

CalOptima retains the right to approve, suspend and terminate individual practitioners, providers and sites from the Delegate's network relative to CalOptima's Medi-Cal Program, even if CalOptima delegates credentialing and re-credentialing decision-making to the Delegate. CalOptima has the right to make the final determination of such participation in the Delegate's network.

Upon request, CalOptima shall provide to the Delegate clinical performance and/or member experience data per CalOptima Policy GG.1637: Assessing Member Experience. The parties agree to comply with the terms and conditions of the Business Associate Agreement between CalOptima and the Delegate.

This Agreement shall become effective January 1, 2021 superseding prior Delegation Acknowledgement and Acceptance Agreements and shall remain in effect for the duration of the Contract for Health Care Services between CalOptima and Delegate, or until superseded by subsequent agreement.

For Delegate:	For CalOptima:
Signature	Signature
MARCUS HOFFMAN	Ladan Khamseh
Print Name	Print Name
Interim SVP/CFO	Chief Operating Officer
Title	Title
05-24-2021	5/25/21
Date	Date

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 1: Quality Improvement (QI)				
Section 1.1: Program Structure and Operations				
1.1.1	QI Program Structure	Yes	The Delegate has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members. The Delegate's QI program description specifies: 1. A QI program structure. 2. The behavioral healthcare aspects of the program. 3. A designated physician has substantial involvement in the QI program. 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program. 5. A QI Committee oversees the QI functions of the Delegate. 6. Objectives for serving a culturally and linguistically diverse membership. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
1.1.2	Annual Work Plan	Yes	The Delegate documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives for improving: a. Quality of clinical care. b. Safety of clinical care. c. Quality of service. d. Members' experience. 2. Timeframe for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
1.1.3	Annual Evaluation	Yes	The Delegate conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices. 1. Adequacy of QI program resources. 2. QI Committee structure. 3. Practitioner participation and leadership involvement in the QI program. 4. Need to restructure or change the QI program for the subsequent year. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
1.1.4	QI Committee Responsibilities	Yes	The Delegate's QI Committee and practitioners develop, implement, and oversee the QI program. The Delegate's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			3. Ensures practitioner participation in the QI program through planning, design, implementation, or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. The Delegate shall further ensure the following: 1. The QI Committee is designated by, and accountable to, the Delegate's governing body. The Delegate's Medical Director or a physician designee shall actively participate on the QI Committee. 2. The Delegate's contracted providers, who are representative of the composition of Delegate's provider network, including but not limited to contracted providers who provide healthcare services to Seniors and Persons with Disabilities (SPD) or chronic conditions, actively participate in QI Committee or medical sub-committee that reports to the QI Committee. 3. The QI Committee meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the QI Committee shall be reported to the Delegate's governing body in writing on a scheduled basis. 4. The QI Committee meeting minutes are maintained. 5. A process is maintained to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of QI Committee members. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation 4. Quarterly report of findings or actions taken as a result of the Quality Improvement activities	
Section 1.2: Health Services Contracting				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
1.2.1	Practitioner Contracts	Yes	The Delegate's contracts with practitioners and providers foster open communication and cooperation with QI activities. The Delegate's contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the Delegate to use their performance data. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
1.2.2	Provider Contracts	Yes	The Delegate's contracts with Delegate providers specifically require that: 1. Providers cooperate with QI activities. 2. Providers allow the plan to use their performance data. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 1.3: Continuity and Coordination of Medical Care				
1.3.1	Identifying Opportunities	Yes	The Delegate annually identifies opportunities to improve coordination of medical care by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and causal analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement. 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
1.3.2	Acting on Opportunities	Yes	The Delegate annually acts to improve coordination of medical care by: 1. Acting on the first opportunity for improvement identified in Section 1.3.1, factor 4. 2. Acting on the second opportunity for improvement identified in Section 1.3.1, factor 5. 3. Acting on the third opportunity for improvement identified in Section 1.3.1, factor 6. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
1.3.3	Measuring Effectiveness	Yes	The Delegate annually measures the effectiveness of improvement actions taken for: 1. The first opportunity. 2. The second opportunity. 3. The third opportunity. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
1.3.4	Transition to Other Care	Yes	The Delegate helps with a member's transition to other care when their benefit ends, if necessary. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 1.4: Continuity and Coordination Between Medical Care and Behavioral Healthcare				
1.4.1	Data Collection	Yes	The Delegate annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	
1.4.2	Collaborative Activities	Yes	The Delegate annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners. 2. Quantitative and causal analysis of data to identify improvement opportunities. 3. Identifying and selecting one opportunity for improvement from Section 1.4.1. 4. Identifying and selecting a second opportunity for improvement from Section 1.4.1. 5. Taking collaborative action to address one identified opportunity for improvement from Section 1.4.1. 6. Taking collaborative action to address a second identified opportunity for improvement from Section 1.4.1. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year) 2. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
1.4.3	Measuring Effectiveness	Yes	The Delegate annually measures the effectiveness of improvement actions taken for: 1. The first opportunity. 2. The second opportunity. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual QI Work Plan (Mid-Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			2. Annual QI Evaluation	
Section 1.5: Delegation of QI				
1.5.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.3	Review of QI Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 2: Population Health Management (PHM)				
Section 2.1: Population Health Management Strategy				
2.1.1	Strategy Description	Yes	The Delegate has a cohesive plan of action for addressing member needs across the continuum of care. The Delegate may use a single document to describe a strategy that applies across all product lines if the document also describes differences in strategy to support different populations, by product line. The strategy describes: 1. Goals and populations targeted for each of the four areas of focus. The four areas of focus are: a. Keeping members healthy. b. Managing members with emerging risk. c. Patient safety or outcomes across settings. d. Managing multiple chronic illnesses 2. Programs or services offered to members. 3. Activities that are not direct member interventions. 4. How member programs are coordinated. 5. How members are informed about available PHM programs. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.1.2	Informing Members	Yes	The Delegate informs members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
Section 2.2: Population Identification				
2.2.1	Data Integration	Yes	The Delegate integrates the following data to use for population health management functions: 1. Medical and behavioral claims or encounters. 2. Pharmacy claims. 3. Laboratory results. 4. Health appraisal results. 5. Electronic health records. 6. Health services programs within the organization. 7. Advanced data sources. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation 4. Health Education Individual Encounters 5. Health Education Other Encounters 6. Perinatal Support services (PSS) Encounters 7. Organ Transplant	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.2.2	Population Assessment	Yes	The Delegate annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			4. Assesses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI). Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
2.2.3	Activities and Resources	Yes	The Delegate annually uses the population assessment to: 1. Review and update its PHM activities to address member needs. 2. Review and update its PHM resources to address member needs. 3. Review community resources for integration into program offerings to address member needs. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.2.4	Segmentation	Yes	At least annually, the Delegate segments or stratifies its entire population into subsets for targeted intervention. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 2.3: Delivery System Supports				
2.3.1	Practitioner or Provider Support	Yes	The Delegate supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data.	CalOptima conducts oversight assessments of the delegated activities, including Audits

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			2. Offering evidence-based or certified decision-making aids. 3. Providing practice transformation support to primary care practitioners. 4. Providing comparative quality information on selected specialties. 5. Providing comparative pricing information for selected services. 6. One additional activity to support practitioners or providers in achieving PHM goals. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	annually or as often as necessary and ongoing Monitoring.
2.3.2	Value-based Payment Arrangements	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 2.4: Wellness and Prevention				
2.4.1	Frequency of Health Appraisal Completion	Yes	The Delegate has the capability to administer the Health Appraisal annually. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.4.2	Topics of Self-Management Tools	Yes	The Delegate offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco use cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			6. Avoiding at-risk drinking. 7. Identifying depressive symptoms Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
Section 2.5: Complex Case Management				
2.5.1	Access to Case Management	Yes	The Delegate helps members with multiple or complex conditions to obtain access to care and services and coordinates their care. The Delegate has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral. 2. Discharge planner referral. 3. Member or caregiver referral. 4. Practitioner referral. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.5.2	Case Management Systems	Yes	The Delegate uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management. 2. Automatic documentation of the staff member's ID and date, and time of action on the case or when interaction with the member occurred. 3. Automated prompts for follow-up, as required by the case management plan. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
2.5.3	Case Management Process	Yes	The Delegate's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of the activities of daily living. 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Initial assessment of life-planning activities. 7. Evaluation of cultural and linguistic needs, preferences, or limitations. 8. Evaluation of visual and hearing needs, preferences, or limitations. 9. Evaluation of caregiver resources and involvement. 10. Evaluation of available benefits. 11. Evaluation of community resources. 12. Development of an individualized case management plan, including prioritized goals, that considers the member and caregiver goals, preferences, and desired level of involvement in the case management plan. 13. Identification of barriers to a member meeting goals or complying with the plan. 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals. 15. Development of a schedule for follow-up and communication with members. 16. Development and communication of member self-management plans. 17. A process to assess member progress against case management plans for members. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.5.4	Initial Assessment	Yes	The Delegate's complex case management files demonstrate that the Delegate follows its documented processes for: 1. Initial assessment of member health status, including condition specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of the activities of daily living (ADL). 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Evaluation of cultural and linguistic needs, preferences, or limitations. 7. Evaluation of visual and hearing needs, preferences, or limitations.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			8. Evaluation of caregiver resources and involvement. 9. Evaluation of available benefits. 10. Evaluation of available community resources. 11. Assessment of life-planning activities. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log 2. Case Management Files	
2.5.5	Case Management-Ongoing Management	Yes	The Delegate's complex case management files demonstrate that the Delegate follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences, and desired level of involvement in the complex case management program. 2. Identification of barriers to meeting goals and complying with the case management plans. 3. Development of schedules for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals, and modification as needed. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log 2. Case Management Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 2.6: Population Health Management Impact				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
2.6.1	Measuring Effectiveness	Yes	At least annually, the Delegate conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.6.2	Improvement and Action	Yes	The Delegate uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program (which shall include the Annual PHM Program) 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 2.7: Delegation of PHM				
2.7.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.7.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
2.7.3	Review of PHM Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.7.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 3: Network Management				
Section 3.1: Availability of Practitioners				
3.1.1	Cultural Needs and Preferences	Yes	The Delegate maintains sufficient numbers and types of primary care, behavioral health, and specialty care practitioners in its network. The Delegate: 1. Assesses the cultural, ethnic, racial, and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
3.1.2	Practitioners Providing Primary Care	Yes	To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the Delegate: 1. Establishes measurable standards for the number of each type of practitioner providing primary care. 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.1.3	Practitioners Providing Specialty Care	Yes	To evaluate the availability of specialists in its delivery system, the Delegate: 1. Defines the types of high-volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high-volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measurable standards for the geographic distribution of each type of high-impact specialists. 5. Analyzes the performance against the established standards at least annually. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
3.1.4	Practitioners Providing Behavioral Healthcare	Yes	To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the Delegate: 1. Defines the types of high-volume behavioral healthcare practitioners. 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner. 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner. 4. Analyzes performance against the standards annually. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 3.2: Accessibility of Services				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.2.1	Access to Primary Care	Yes	Using valid methodology, the Delegate collects and performs an annual analysis of data to measure its performance against standards for access to: 1. Regular and routine care appointments. 2. Urgent care appointments. 3. After-hours care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation 4. Access and Availability Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
3.2.2	Access to Behavioral Healthcare	Yes	Using valid methodology, the Delegate annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours.* 2. Urgent care within 48 hours.* 3. Initial visit for routine care within 10 business days. 4. Follow-up routine care. *NCQA critical factors Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation 4. Access and Availability Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.2.3	Access to Specialty Care	Yes	Using valid methodology, the Delegate annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care. 2. High-impact specialty care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation 4. Access and Availability Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 3.3: Assessment of Network Adequacy				
3.3.1	Assessment of Member Experience Accessing the Network	Yes	The Delegate annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services (from Section 6.7.3 and Section 6.7.4). 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services (from Section 6.7.5). 3. Compiling and analyzing nonbehavioral requests for and utilization of Out-of-work services. 4. Compiling and analyzing behavioral healthcare requests for and utilization of Out-of-Network services. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
3.3.2	Opportunities to Improve Access to Nonbehavioral	Yes	The Delegate annually:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
	Healthcare Services		1. Prioritizes opportunities for improvement identified from analyses of availability (Sections 3.1.1,3.1.2,3.1.3), accessibility (Sections 3.2.1 and 3.2.3) and member experience accessing the network (Section 3.3.1, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
3.3.3	Opportunities to Improve Access to Behavioral Healthcare Services	Yes	The Delegate annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (Sections 3.1.1 and 3.1.4), accessibility (Section 3.2.2) and member experience accessing the network (Section 3.3.1, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 3.4: Continued Access to Care				
3.4.1	Notification of Termination	Yes	The Delegate uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. The Delegate notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner. Termination date is the date when the termination becomes effective.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Provider Termination Quarterly Report	
3.4.2	Continued Access to Practitioners	Yes	The Delegate shall provide continuity of care for a member involuntarily transitioning between providers or practitioners to prevent the delay or interruption of medically necessary covered services, in accordance with the terms and conditions of CalOptima Policies. The Delegate shall allow for the completion of services, upon member request, in accordance with CalOptima Policies, for the following conditions: 1. Acute condition, serious chronic condition, pregnancy, terminal illness, or the care of a newborn child between birth through 36 months; or 2. Performance of a surgery or other procedure that is authorized by the Delegate as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the contract's termination date or within 180 calendar days of the effective date of coverage for a newly covered member. The Delegate shall ensure continuation of treatment, upon member request, through the current period of active treatment for acute and chronic conditions not to exceed 12 months, except as provided for Medi-Cal members eligible with the Whole Child Model (WCM) program. The Delegate shall ensure continuation of care, upon member request, for the duration of the pregnancy, which includes the three trimesters and immediate postpartum period. The Delegate shall comply with the following CalOptima Policies: 1. Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services (Medi-Cal) 2. Policy GG.1304: Continuity of Care during Health Network or Provider Termination (Medi-Cal) Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 3.5: Physician and Hospital Directories				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.5.1	Physician Directory Data	Yes	The Delegate has a web-based physician directory that includes the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Board certification. 7. Accepting new patients. 8. Languages spoken by the physician or clinical staff. 9. Office locations and phone numbers. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.2	Physician Directory Updates	Yes	The Delegate updates its web-based physician directory within 30 calendar days of receiving new information from the physician. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.3	Assessment of Physician Directory Accuracy	Yes	Using valid methodology, the Delegate performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers. 2. Accuracy of hospital affiliations. 3. Accuracy of accepting new patients. 4. Awareness of physician office staff of physicians' participation in the Delegate's network. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.5.4	Identifying and Acting on Opportunities	Yes	Based on results of the analysis performed in Section 3.5.3, at least annually, the Delegate: 1. Identifies opportunities to improve the accuracy of the information in its physician directories. 2. Takes actions to improve the accuracy of the information in its physician directories. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.5	Searchable Physician Web-based Directory	Yes	The Delegate's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Accepting new patients. 7. Languages spoken by the physician or clinical staff. 8. Office locations. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.6	Hospital Directory Data	Yes	The Delegate has a web-based hospital directory that includes the following: 1. Hospital name. 2. Hospital location and phone number. 3. Hospital accreditation status. 4. Hospital quality data from recognized sources. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.5.7	Hospital Directory Updates	Yes	The Delegate updates its web-based hospital directory information within 30 calendar days of receiving new information from the hospital. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.8	Searchable Hospital Web-based Directory	Yes	The Delegate's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name. 2. Hospital location. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.9	Usability Testing	Yes	The Delegate evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level. 2. Intuitive content organization. 3. Ease of navigation. 4. Directories in additional languages, if applicable to the membership. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
3.5.10	Availability of Directories	Yes	The Delegate makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print. 2. Telephone.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	
Section 3.6: Delegation of Network Management				
3.6.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.6.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.6.3	Review of Delegated Activities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.6.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 4: Utilization Management (UM)				
Section 4.1: UM Program Structure				
4.1.1	Written Program Description	Yes	The Delegate has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. The Delegate's UM program description includes the following: 1. A written description of the program structure: a. UM staff member's assigned activities. b. UM staff who have the authority to deny coverage. c. Involvement of a designated physician and designated behavioral healthcare practitioner. d. The process for evaluating, approving, and revising the UM program, and the staff responsible for each step. e. The UM program's role in the QI program, including how the Delegate collects UM information and uses if for QI activities. f. The Delegate's process for handling appeals and making appeal determinations. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior-level physician in UM program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and process used to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. For factors 5 and 6 above, the Delegate's UM program description specifies: a. The UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including: i. How the Delegate develops and selects criteria. ii. How the Delegate reviews, updates and modifies criteria. b. How medical necessity and benefits coverage for inpatient and outpatient services are determined.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			c. The description of the data and information the Delegate uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision–making process. d. The triage and referral process for behavioral healthcare services (if applicable). e. How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable). Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual Work Plan (Mid- Year) 3. Annual UM Evaluation (Previous Year)	
4.1.2	Annual Evaluation	Yes	The Delegate annually evaluates and updates the UM program, as necessary. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.2: Clinical Criteria for UM Decisions				
4.2.1	UM Criteria	Yes	The Delegate applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Delegate: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs and considers at least the following individual characteristics when applying criteria: a. Age. b. Co-morbidities. c. Complications. d. Progress of treatment.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			e. Psychosocial situation. f. Home environment, when applicable. 3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting, and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	
4.2.2	Availability of Criteria	Yes	The Delegate: 1. States in writing how practitioners can obtain UM criteria. 2. Makes the UM criteria available to its practitioners and members upon request. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.2.3	Consistency in Applying Criteria	Yes	At least annually, the Delegate: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 4.3: Communication Services				
4.3.1	Access to Staff	Yes	Members and practitioners can access staff to discuss UM issues. The Delegate provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.4: Appropriate Professionals				
4.4.1	Licensed Health Professionals	Yes	UM decisions are made by qualified health professionals. The Delegate has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.4.2	Use of Practitioners for UM Decisions	Yes	The Delegate has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training, or professional experience in medical or clinical practice. 2. A current license to practice without restriction or an administrative license to review UM cases. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.4.3	Practitioner Review of Nonbehavioral Healthcare Denials	Yes	The Delegate uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity. 1. Medical reviewer signature or unique identifier (electronic or handwritten) must be noted within the file for all adverse decisions. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.4.4	Practitioner Review of Behavioral Healthcare Denials	Yes	The Delegate uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.4.5	Practitioner Review of Pharmacy Denials	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:**	CalOptima conducts oversight assessments of the delegated activities, including Audits

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			The Delegate uses a physician or pharmacist to review any pharmacy denials based on medical necessity. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	annually or as often as necessary and ongoing Monitoring.
4.4.6	Use of Board-Certified Consultants	Yes	The Delegate: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. Provides evidence that it uses board-certified consultants for medical necessity determinations. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.5: Timeliness of UM Decisions				
4.5.1	Notification of Nonbehavioral Decisions	Yes	The Delegate makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The Delegate adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. For urgent concurrent decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 2. For urgent preservice decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. For nonurgent preservice decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within five (5) working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring. CalOptima's oversight may include, without limitations, reviews of a sample of Delegate's UM denials in order to ensure service levels, quality, and compliance with applicable Standards and Requirements.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			4. For post-service decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. The Delegate shall further comply with all applicable Standards and Requirements for the time frames for notification for non-behavioral UM decisions, including CalOptima Policy GG.1508: Authorization and Processing of Referrals. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.5.2	Notification of Behavioral Healthcare Decisions	Yes	The Delegate adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. For urgent concurrent decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 2. For urgent preservice decisions, the Delegate provides electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. For nonurgent preservice decisions, the Delegate provides electronic or written notification of the decision to practitioners and members within five (5) working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request. 4. For post-service decisions, the Delegate provides electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. The Delegate shall further comply with all applicable Standards and Requirements for the time frames for notification for behavioral UM decisions, including CalOptima Policy GG.1508: Authorization and Processing of Referrals. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring. CalOptima's oversight may include, without limitations, reviews of a sample of Delegate's UM denials in order to ensure service levels, quality, and compliance with applicable Standards and Requirements.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.5.3	Notification of Pharmacy Decisions	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** The Delegate adheres to the time frames for notifying members and prescribing practitioners of pharmacy benefit UM decisions, in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process. The Delegate shall provide a written response to approve, modify, delay for medical necessity information from the prescribing practitioner, or deny an authorization request within: 1. 24 hours after receipt of an urgent preservice request. 2. 24 hours after receipt of an urgent concurrent request. 3. 24 hours after receipt of a preservice request. 4. 30 calendar days after receipt of a retrospective request. The Delegate adheres to the time frames for notifying members and practitioners of medical physician administered drug (PAD) authorization decisions, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The Delegate shall further comply with all applicable Standards and Requirements for the time frames for notification for pharmacy UM decisions, including California Welfare and Institutions Code Section 14185(a)(1). Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.5.4	UM Timeliness Report	Yes	The Delegate monitors and submits a report for timeliness of: 1. Nonbehavioral UM decision making. 2. Notification of nonbehavioral UM decisions. 3. Behavioral UM decision making. 4. Notification of behavioral UM decisions.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** 1. Pharmacy UM decision making. 2. Notification of pharmacy UM decisions	
4.5.5	Interim - Policies and Procedures	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.6: Clinical Information				
4.6.1	Relevant Information for Nonbehavioral Healthcare Decisions	Yes	The Delegate uses all information relevant to a member's care when it makes coverage decisions. There is documentation that the Delegate gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.6.2	Relevant Information for Behavioral Healthcare Decisions	Yes	There is documentation that the Delegate gathers relevant clinical information consistently to support behavioral healthcare UM decision making.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.6.3	Relevant Information for Pharmacy Decisions	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** The Delegate documents that it consistently gathers relevant information to support pharmacy UM decision making. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.7: Denial Notices				
4.7.1	Discussing a Denial with a Reviewer	Yes	The Delegate gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. The name and direct telephone number, if available, or general number and extension number of the physician issuing the denial must be provided to the requesting provider. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.2	Written Notification of Nonbehavioral	Yes	The Delegate's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
	Healthcare Denial		2. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request. In addition to the foregoing, the written notification to the provider must include the name and direct telephone number, if available, or general number and extension number of the decision maker. The Delegate shall further comply with all applicable Standards and Requirements for written notice of action, including Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.7.3	Nonbehavioral Healthcare Notice of Appeal Rights/Process	Yes	The Delegate's written non-behavioral healthcare denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. a. The time frame for filling an expedited appeal. b. The Delegate's time frame for deciding the expedited appeal. c. The procedure for filling an expedited appeal, including where to direct the appeal and information to include in the appeal. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.7.4	Discussing a Behavioral Healthcare Denial with a Reviewer	Yes	The Delegate provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. Behavioral Health Comprehensive Diagnostic Exam (CDE) Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.5	Written Notification of Behavioral Healthcare Denials	Yes	The Delegate's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based. 3. A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.6	Behavioral Healthcare Notice of Appeal Rights/Process	Yes	The Delegate's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal. 2. An explanation of the appeal process, including members' right to representation and appeal time frames.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. a. The time frame for filing an expedited appeal. b. The Delegate's time frame for deciding the appeal. c. The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. Mental Health Grievances and Appeals	
4.7.7	Discussing a Pharmacy Denial with a Reviewer	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** The Delegate gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.8	Written Notification of Pharmacy Denials	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** The Delegate's written notification of pharmacy denials to members and their treating practitioners contains the following information:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based. 3. A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.7.9	Pharmacy Notice of Appeal Rights/Process	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:** The Delegate's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal. 2. An explanation of the appeal process, including members' right to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. a. The time frame for filling an expedited appeal. b. The Delegate's time frame for deciding the appeal. c. The procedure for filling an expedited appeal, including where to direct the appeal and information to include in the appeal. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
Section 4.8: Policies for Appeals				
4.8.1	Member Internal Appeals	Yes	There is an established, impartial process for resolving members' disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The Delegate's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least 180 calendar days after notification of the denial for the member to file an appeal. 2. Documenting the substance of the appeal and any actions taken. 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved. 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal. 5. Appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination. 6. Appointment of at least one person to review an appeal who is a practitioner in the same or a similar specialty. 7. The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request. 8. The decision for a post service appeal and notification to the member within 60 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 10. Notification to the member about further appeal rights. 11. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based. 12. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			13. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review. 14. Allowing an authorized representative to act on behalf of the member. 15. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 16. Continued coverage pending the outcome of an appeal. The Delegate shall further comply with all applicable Standards and Requirements for registering and responding to written internal appeals from members, including CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	
Section 4.9: Appropriate Handling of Appeals				
4.9.1	Member Preservice and Post Service Appeals	Yes	The Delegate has a full and fair process for resolving member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service. The Delegate's appeal files contain the following information: 1. Documentation of the substance of appeals. 2. Investigation of appeals. 3. Appropriate response to the substance of appeals. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. DHCS NMT/NEMT Report 4. DHCS Quarterly Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			5. Grievances Volume Report 6. Community-Based Adult Services (CBAS) Report	
4.9.2	Timeliness of the Member Appeal Process	Yes	Timeliness of the Delegate's preservice, post service, and expedited appeal processes is within the specified time frames: 1. The Delegate resolves preservice appeals within 30 calendar days of receipt of the request. 2. The Delegate resolves post service appeals within 30 calendar days of receipt of the request. 3. The Delegate resolves expedited appeals within 72 hours of receipt of the request. The Delegate shall further comply with all applicable Standards and Requirements for time frames for preservice, post service, and expedited appeals processing, including, CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.9.3	Appeal Reviewers	Yes	The Delegate provides non-subordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.9.4	Notification of Appeal Decision/Rights	Yes	The Delegate's internal appeal files indicate notification to members of the following: 1. Specific reasons for the appeal decision, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			4. Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge, upon request. 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review. 6. A description of the next level of appeal, either within the Delegate or to an independent external organization, as applicable, along with any relevant written procedures. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.9.5	Final Internal and External Appeal Files	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
4.9.6	Appeals Overturned by the IRO	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
4.9.7	Provider Level 1 UM Appeals	Yes	Level 1 UM Appeals involve disputes related to utilization management decisions by the Delegate, including adverse benefit determinations based on medical necessity. Provider Level 1 UM Appeals only apply to post service appeals. Member preservice, expedited, and post service appeals are addressed in Sections 4.9.1. and 4.9.2. The Delegate shall process and resolve Provider Level 1 UM Appeals within contractual and regulatory timeframes as established by CalOptima and in accordance with applicable Standards and Requirements, including CalOptima Policies. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. UM Retrospective Appeal Universe	CalOptima conducts oversight assessments of delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.9.8	Provider Level 2 UM Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 4.10: Evaluation of New Technology				
4.10.1	Written Process	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
4.10.2	Description of the Evaluation Process	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
Section 4.11: Procedures for Pharmaceutical Management				
4.11.1	Pharmaceutical Management Procedures	Yes	The Delegate's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures. 2. A process that uses clinical evidence from appropriate external organizations. 3. A process to include pharmacists and appropriate practitioners in the development of procedures. 4. A process to provide procedures to practitioners annually and when it makes changes. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.11.2	Pharmaceutical Restrictions/ Preferences	Yes	Annually and after updates, the Delegate communicates to members and prescribing practitioners: 1. A list of pharmaceuticals, including restrictions and preferences. 2. How to use the pharmaceutical management procedures. 3. An explanation of limits or quotas. 4. How prescribing practitioners must provide information to support an exception request. 5. The Delegate's process for generic substitution, therapeutic interchange and step-therapy protocols. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	
4.11.3	Pharmaceutical Patient Safety Issues	Yes	The Delegate's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification. 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.11.4	Reviewing and Updating Procedures	Yes	With the participation of physicians and pharmacists, the Delegate annually: 1. Reviews the procedures. 2. Reviews its list of pharmaceuticals. 3. Updates the procedures as appropriate. 4. Updates the list of pharmaceuticals as appropriate. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.11.5	Considering Exceptions	Yes	Delegate does not utilize Prior Authorization rules that affect drug coverage. **If the Delegate initiates a pharmacy Prior Authorization process, the following shall apply:**	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			The Delegate has exception policies and procedures that describe the process for: 1. Making an exception request based on medical necessity* 2. Obtaining medical necessity information from prescribing practitioners* 3. Using appropriate pharmacists and practitioners to consider exception requests. 4. Timely handling of requests. 5. Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request. *NCQA critical factors Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	
Section 4.12: UM System Controls				
4.12.1	UM Denial System Controls	Yes	The Delegate has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Specify system security controls in place to protect data from unauthorized modification. a. Limiting physical access to the system. b. Preventing unauthorized access and changes to system data. c. Password-protecting electronic systems, including requirements to: use strong passwords, avoid writing down passwords, use different passwords for different accounts, and change passwords when requested by staff or if passwords are compromised.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			d. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to: change passwords when appropriate and disable or remove passwords of employees who leave the organization. 7. Specify how the Delegate audits the processes and procedures in factors 1-6. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	
4.12.2	UM Appeal System Controls	Yes	The Delegate has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. a. Limiting physical access to the system. b. Preventing unauthorized access and changes to system data. c. Password-protecting electronic systems, including requirements to: use strong passwords, avoid writing down passwords, use different passwords for different accounts, and change passwords when requested by staff or if passwords are compromised. d. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to: change passwords when appropriate and disable or remove passwords of employees who leave the organization. 7. Specify how the Delegate audits the processes and procedures in factors 1-6. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 4.13: Delegation of UM				

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.13.1	Delegation Agreements	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.3	Review of the UM Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.14: Second Opinion				
4.14.1	Second Opinion	Yes	The Delegate provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. 1. If the Delegate is unable to provide a necessary and covered service to a member in-network, the organization must adequately and timely cover these services of out of network, for as long as the Delegate is unable to provide the services. 2. If the Delegate approves a member to out of network because it is unable to provide a necessary and covered service in-network, the Delegate coordinates payment with out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network. If the member is requesting a second opinion from the member's primary care practitioner/physician (PCP), the member may receive the second opinion from an appropriately qualified health care professional of the member's choice from within the Delegate's provider network.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			If the member is requesting a second opinion from a specialist, the member may receive the second opinion from any specialist of the same or equivalent specialty of the member's choice within the Delegate's provider network. 1. If a specialist is not available within the Delegate's provider network, a Delegate shall arrange for the second opinion from a non-contracted provider and shall incur the cost or negotiate the fee arrangement of that second opinion. The Delegate shall authorize a request for a third opinion if the recommendations of the first and second practitioner differ regarding the need for a medical procedure and a member, member's authorized representative, physician, or provider requests such third opinion. The Delegate shall further comply with all applicable Standards and Requirements, including CalOptima Policy GG.1538: Referral of Second Opinion. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 5: Credentialing and Recredentialing (CR)				
Section 5.1: Credentialing Policies				
5.1.1	Practitioner Credentialing Guidelines	Yes	Delegate shall document its process for credentialing and re-credentialing licensed independent practitioners it employs or with whom it contracts and who fall within its scope of authority and action. The Delegate's credentialing policies specify: 1. The types of practitioners to credential and recredential. 2. The verification sources used. 3. The criteria for credentialing and recredentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 7. The process for notifying practitioners if information obtained during the credentialing process varies substantially from the information they provided to the Delegate. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. 9. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. 12. The process for ensuring the following are reviewed during initial and recredentialing process: a. Quality improvement activities and member complaints. b. Review of CMS Opt-out, CMS Exclusions/Sanctions, and CMS Preclusion.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			c. Practitioners Medi-Cal enrollment. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
5.1.2	Practitioner Rights	Yes	The Delegate notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. 3. Receive the status of their credentialing or recredentialing application, upon request. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.1.3	Credentialing Systems Controls	Yes	The Delegate's credentialing process describes: 1. How primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification 3. Staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. a. Limiting physical access to credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. b. Preventing unauthorized access, changes to and release of credentialing information. c. Password-protecting electronic systems, including user requirements to: use strong passwords, avoid writing down passwords, use different passwords for different accounts, and change passwords when requested by staff or if passwords are compromised. d. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to: change passwords when appropriate, and disable or remove passwords if employees leave the organization.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			5. How the Delegate audits the processes and procedures in factors 1-4. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
Section 5.2: Credentialing Committee				
5.2.1	Credentialing Committee	Yes	The Delegate obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions. The Delegate's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. 2. Reviews credentials for practitioners who do not meet established thresholds. 3. Ensures that files that meet established criteria are reviewed and approved by a Medical Director or designated physician. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.3: Credentialing Verification				
5.3.1	Verification of Credentials	Yes	The Delegate conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. The Delegate verifies credentialing information through primary sources, unless otherwise indicated. The Delegate verifies that the following are within the prescribed time limits: 1. A current and valid license to practice. 2. A valid DEA or CDS certificate, if applicable. 3. Education and training, as specified in the NCQA Standards and Guidelines.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			4. Board certification status, if applicable. 5. Work history. 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
5.3.2	Sanction Information	Yes	The Delegate verifies the following sanction information for credentialing:: 1. State sanctions, restrictions on licensure or limitations on scope of practice. 2. Medicare and Medicaid sanctions. 3. Medi-Cal Suspended & Ineligible 4. Medicare Opt-Out 5. Excluded Parties List System/System for Award Management (EPLS/SAM) 6. CMS Preclusions Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.3.3	Credentialing Application	Yes	The Delegate performs primary source verification and credentialing and re-credentialing decision-making, which includes using an application and signed attestation. The Delegate ensures applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Hospital admitting privileges or coverage	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			7. Current and signed attestation confirming the correctness and completeness of the application. 8. A current facility site review is included for PCP in the credentialing file. 9. Process and procedure for identifying HIV/AIDS Specialist Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
Section 5.4: Recredentialing Cycle Length				
5.4.1	Recredential-ing Cycle Length	Yes	The length of the recredentialing cycle is within the required 36-month time frame. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.5: Ongoing Monitoring and Interventions				
5.5.1	Ongoing Monitoring and Interventions	Yes	Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The Delegate implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions (i.e., Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, Excluded Parties List System/System for Award Management (EPLS/SAM), CMS Preclusion). 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
Section 5.6: Notification to Authorities and Practitioner Appeal Rights				
5.6.1	Actions Against Practitioners	Yes	The Delegate uses objective evidence and patient care considerations to decide on altering a practitioner's relationship with Delegate if the practitioner does not meet Delegate's quality standards. The Delegate has policies and procedures for: 1. The range of actions available to the Delegate. 2. Making the appeal process known to practitioners. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.7: Assessment of Medi-Cal Organizational Providers				
5.7.1	Review and Approval of Provider	Yes	The Delegate assesses and approves, initially and in an ongoing manner, Medi-Cal provider organizations. The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. Ensures that the provider is Medi-Cal enrolled. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			2. Credentialing Universe Monthly Case Files	
5.7.2	Medical Providers	Yes	The Delegate includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.7.3	Behavioral Healthcare Providers	No	This function or activity is not applicable for Medi-Cal because behavioral Health facilities are carved out to the Orange County Health Care Agency (HCA).	This function or activity is not applicable for Medi-Cal because behavioral health facilities are carved out to the HCA.
5.7.4	Assessing Medical Providers	Yes	The Delegate assesses contracted medical health care providers against the requirements and within the timeframe in Section 5.7.1. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.7.5	Assessing Behavioral Healthcare Providers	No	This function or activity is not applicable for Medi-Cal because behavioral health facilities are carved out to the HCA.	This function or activity is not applicable for Medi-Cal because behavioral health facilities are carved out to the HCA.
Section 5.8: Delegation of CR				
5.8.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
5.8.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
5.8.3	Review of the Delegate's Credentialing Activities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
5.8.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 6: Member Experience (ME)				
Section 6.1: Statement of Members' Rights and Responsibilities				
6.1.1	Rights and Responsibilities Statement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.1.2	Distribution of Rights Statement	Yes	The Delegate distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners when they join the network. 4. Existing practitioners, if requested. Delegate shall submit requisite documentation for Annual Audit pursuant to the CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 6.2: Subscriber Information				
6.2.1	Subscriber Information	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.2.2	Interpreter Services	Yes	Based on the linguistic need of its subscribers, the Delegate provides interpreter or bilingual services in its Member Services department and telephone functions. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Health Network Dashboard 2. Interpreter Services Utilization Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 6.3: Marketing Information				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
6.3.1	Materials and Presentations	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
6.3.2	Communicating with Prospective Members	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
6.3.3	Assessing Member Understanding	No	Not Applicable for Medi-Cal Program	Not Applicable for Medi-Cal Program
Section 6.4: Intentionally Left Blank				
Section 6.5: Pharmacy Benefit Information				
6.5.1	Pharmacy Benefit Information: Website	Yes	Members can complete the following actions on the Delegate 's Website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Kaiser Pharmacy Monitoring Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
6.5.2	Pharmacy Benefits Information: Telephone	Yes	Members can complete the following actions via the Delegate’s telephone call center in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired, mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 2. Kaiser Pharmacy Monitoring Report	
6.5.3	QI Process on Accuracy of Information	Yes	The Delegate 's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyzes data results. 3. Acts to improve identified deficiencies. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Kaiser Pharmacy Monitoring Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
6.5.4	Pharmacy Benefit Updates	Yes	The Delegate updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Kaiser Pharmacy Monitoring Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 6.6: Personalized Information on Health Plan Services				
6.6.1	Functionality: Website	Yes	The Delegate ensures that members can complete each of the following activities on the Delegate's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
6.6.2	Functionality: Telephone	Yes	To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
6.6.3	Quality and Accuracy of Information	Yes	At least annually, the Delegate must evaluate the quality and accuracy of the information it provides to its members via the web and telephone, by: 1. Collecting data on quality and accuracy of information provided 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
6.6.4	E-Mail Response Evaluation	Yes	The Delegate: 1. Has a process for responding to member email inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of email responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually acts to improve identified deficiencies. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 6.7: Member Experience				
6.7.1	Policies and Procedures for Complaints	Yes	The Delegate has policies and procedures for registering and responding to oral and written complaints that include: 1. Documentation of the substance of complaints and actions taken. 2. Investigation of the substance of complaints. 3. Notification to members of the resolution of the complaint and, if there is an adverse decision, the right to appeal. 4. Standards for timeliness, including standards for urgent situations. 5. Provision of language services for the complaint process. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary. Members have the option to file a complaint directly with CalOptima.
6.7.2	Policies and Procedures for Appeals	Yes	The Delegate has policies and procedures for registering and responding to oral and written appeals of decisions that are not about coverage that include: 1. Documentation of the substance of appeals and actions taken. 2. Investigation of the substance of appeals. 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate. 4. Standards for timeliness, including standards for urgent situations. 5. Provision of language services for the appeal process. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary. Members have the option to file an appeal directly with CalOptima.
6.7.3	Annual Assessment of Nonbehavioral Healthcare	Yes	Using valid methodology, the Delegate annually analyzes nonbehavioral complaints and appeals for each of the five required categories. 1. Quality of care. 2. Access. 3. Attitude and services	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary. and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
	Complaints and Appeals		4. Billing and financial issues. 5. Quality of practitioner office site. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	
6.7.4	Nonbehavioral Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.5	Annual Assessment of Behavioral Healthcare and Services	Yes	Using valid methodology, the Delegate annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the following five required categories: a. Quality of care. b. Access. c. Attitude and services d. Billing and financial issues. e. Quality of practitioner office site. 2. Conducts a member experience survey. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual QI Program 2. Semi-Annual QI Work Plan (Mid-Year) 3. Annual QI Evaluation	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary. and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
6.7.6	Behavioral Healthcare Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.8: Delegation of ME				
6.8.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.8.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.8.3	Review of Performance	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.8.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 7: Claims				
Section 7.1: Claims				
7.1.1	Claims Processing and Exclusion and Preclusion Monitoring	Yes	1. The Delegate shall identify and acknowledge electronic claims within two (2) working days of the date of receipt of the claim. 2. The Delegate shall identify and acknowledge paper claims within fifteen (15) working days of the date of receipt of the claim. 3. The Delegate shall not reimburse or make payment for services provided under the medical direction of a provider or entity that is verified to be suspended, debarred, precluded, or excluded from participation in federal or state health care programs. 4. Delegate shall verify provider or entity's participation status as required by CalOptima Policy HH.2021: Exclusion and Preclusion Monitoring. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report 4. Preclusion List Report for Member Notifications Only	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.2	Claims Forwarding	Yes	The Delegate shall forward all claims received incorrectly to the correct entity within ten (10) working days of the receipt of the claim. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.3	Interest Payment of Emergency Services Claims	Yes	For late payment on a complete claim for emergency services, the Delegate shall automatically include the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof, on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report	
7.1.4	Timeliness of Claims Processing	Yes	1. The Delegate shall process and adjudicate ninety percent (90%) of all non-contracted and contracted clean claims for covered services provided to members within thirty (30) calendar days after Delegate's receipt of such claims (from the earliest date stamp through the date the payment check or notice was mailed). 2. The Delegate shall process and adjudicate ninety-nine percent (99%) of all clean claims for covered services provided to members within ninety (90) calendar days after Delegate's receipt of such claims. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report 4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.5	Claims Processing and Coordination of Benefits	Yes	In accordance with the most current DHCS regulatory guidance during the time period of review: 1. The Delegate shall have procedures in place to identify payers that are primary and secondary to determine amounts payable, and coordinate benefits for members with Other Health Coverage (OHC), in accordance with the Medicare and Medi-Cal crossover claims guidelines. 2. The Delegate shall identify and report to CalOptima any member reports of other employer health coverage or other private or public health insurance. 3. Delegate shall identify and report to CalOptima any Explanation of Payment (EOP) or Explanation of Medical Benefits (EOMB) received with other coverage payment. 4. If the member has OHC, the Delegate shall consider the OHC plan as the member's primary health plan. 5. The Delegate shall remain the secondary health plan and payer of last sort.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. DHCS Post-Payment Recovery Report (Medi-Cal Only) 5. Kaiser WCM Claim Detail *6.* Claims Timeliness Report	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions – Level 1	Yes	The Delegate shall accurately conduct claims processing. The Delegate shall process and resolve Level 1 provider disputes related to claims payment decisions within contractual and regulatory timeframes as established by CalOptima and in accordance with applicable Standards and Requirements, including CalOptima Policies. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. DHCS Post-Payment Recovery Report (Medi-Cal Only) 5. Claims Timeliness Report 6. Provider Dispute Resolution (PDR) XML Universe 7. PDR Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions – Level 2	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
7.1.8	Third Party Liability (TPL)	Yes	1. Delegate shall make no claim for recovery of the value of covered services rendered to a member in an instance, or case, where an action by a member involving casualty insurance, tort, or Workers' Compensation liability of a third party could result in a member's recovery of funds to which the Department of Health Care Services (DHCS) has lien rights. a. The Delegate shall notify CalOptima within five (5) calendar days of becoming aware of an instance, or case, of potential TPL relative to covered services provided to a member. 2. The Delegate shall respond within twenty (20) calendar days of a request from CalOptima and/or DHCS for a Medi-Cal member's paid claims data and include an itemized list of all services provided to the member from the date of injury forward. The Delegate shall further comply with all applicable Standards and Requirements, including CalOptima Policy FF.2007: Reporting of Potential Third Party Liability. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. DHCS Post-Payment Recovery Report (Medi-Cal Only) 5. Claims Timeliness Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 8: Provider Complaint				
Section 8.1: Provider Complaint Processing				
8.1.1	Provider Complaint Processing	No	This function or activity related to Provider Complaint Processing is retained by CalOptima and is not delegated to the Delegate. Provider Complaint Processing involves disputes related to decisions or actions taken by the Delegate, including disputes about the CalOptima Program, but excluding utilization management disputes and claims payment disputes which are separately addressed in Sections 4.9.7 and 7.1.6 respectively.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 9: Medicaid (MED)				
Section 9.1: Medicaid Benefits and Services				
9.1.1	Notification of Termination of a Practitioner or Practice Group	Yes	The Delegate provides written notification to affected members of termination of a practitioner or practice group within 15 calendar days after receipt or issuance of the termination notice. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Provider Termination Quarterly Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 9.2: Practice Guidelines				
9.2.1	Adoption of Practice Guidelines	Yes	The Delegate adopts at least four evidence-based clinical practice guidelines, approved by its QI Committee, that: 1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field. 2. Consider the needs of the organization's members. 3. Are adopted in consultation with contracted health care professionals. 4. Are reviewed and updated at least every two years, as applicable. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
9.2.2	Distributions of Practice Guidelines	Yes	The Delegate distributes the evidence-based guidelines it adopted in 9.2.1 to the appropriate practitioners and to members and potential members, upon request. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 9.3: Practitioner Office Site Quality				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
9.3.1	Site Visits and Ongoing Monitoring	Yes	The Delegate implements appropriate interventions by: 1. Continually monitoring member complaints for all practitioner sites. 2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. 3. Instituting actions to improve offices that do not meet site standards and thresholds set by CalOptima for the following: a. Accessibility equipment. b. Physical accessibility. c. Physical appearance. d. Adequacy of waiting and examining room space. e. Adequacy of medical/treatment record keeping. 4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the site standards and thresholds set by CalOptima. 5. Documenting follow-up visits for offices that had subsequent deficiencies. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual Site Visit Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 9.4: Care Coordination				
9.4.1	Coordinating Health Care Services for Members	Yes	The Delegate's care coordination process includes provisions for all members, including: 1. Having a person or entity formally assigned to coordinate health care services provided to members. 2. Providing the contact information of the individuals coordinating healthcare services to members. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Individual Care Plan/Health Action Plan (ICP/HAP) bundle 2. Interdisciplinary Care Team (ICT) Bundle	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
9.4.2	Maintaining and Sharing Member	Yes	The Delegate requires: 1. Practitioners to maintain member health records, as appropriate and in accordance with professional standards.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
	Health Records		2. Practitioners to share member health records, as appropriate and in accordance with professional standards. 3. Providers to maintain member health records, as appropriate and in accordance with professional standards. 4. Providers to share member health records, as appropriate and in accordance with professional standards. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Semi-Annual Site Visit Report	
Section 9.5: Informing Members of Services				
9.5.1	Informing Members About the QI Program	Yes	The Delegate annually makes information about its QI program available to members. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 9.6: UM Decisions About Payment and Services				
9.6.1	Affirmative Statement About Incentives	Yes	The Delegate distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The Delegate does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual Work Plan (Mid-Year) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 9.7: Information Services for Members				

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
9.7.1	Providing Information to Medicaid Members in the Practitioner Directory	Yes	The Delegate's written practitioner directory is available to existing and potential members: 1. In regular and large print. 2. In alternative formats, upon request, free of charge. 3. In the prevalent non-English languages in its service area. 4. With taglines in the prevalent non-English languages in the state. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
9.7.2	Providing Information to Medicaid Members in Denial Notifications	Yes	Denial notifications sent by the Delegate to existing members are available: 1. In regular and large print. 2. In alternative formats, upon request, free of charge. 3. In the prevalent non-English languages in its service area. 4. With taglines in the prevalent non-English languages in the state. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
9.7.3	Providing Information to Members in Appeal and Grievance Notifications	Yes	Appeal and grievance notifications sent to existing and potential members by the Delegate are available: 1. In regular and large print. 2. In alternative formats, upon request, free of charge. 3. In the prevalent non-English languages in its service area. 4. With taglines in the prevalent non-English languages in the state. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
9.7.4	Interpreter Services for	Yes	The Delegate provides oral interpreter or bilingual services in all languages to: 1. Existing members. 2. Prospective members.	CalOptima conducts oversight assessments of the delegated activities, including Audits

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
	Medicaid Members		Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Interpreter Services Utilization Report 2. Health Network Dashboard	annually or as often as necessary and ongoing Monitoring.
9.7.5	Usability Testing of Member Materials	Yes	The Delegate evaluates its distributed materials for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Font size. 2. Reading level. 3. Intuitive content organization. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 9.8: Member Communications				
9.8.1	Offering Special Communication Assistance	Yes	The Delegate provides communication assistance, free of charge, to meet the special needs of members. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
Section 9.9: Practitioner and Provider Directories				
9.9.1	Directory Data	Yes	The Delegate's directory includes the following information: 1. The website address. 2. Office/facility accommodations for members with disabilities or special needs. 3. Cultural and linguistic capabilities of the physician or clinical staff. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.
9.9.2	Pharmacy Directory Data	Yes	The Delegate's directory includes the following information about available pharmacies: 1. Name.	CalOptima conducts oversight assessments of the delegated activities, including Audits

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			2. Pharmacy locations and phone numbers. 3. Pharmacy website address. 4. Pharmacy or facility accommodations for people with disabilities or special needs. 5. Cultural and linguistic capabilities of the pharmacist and pharmacy staff. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. 274 File	annually or as often as necessary and ongoing Monitoring.
9.9.3	Behavioral Healthcare Directory Data	Yes	The Delegate's behavioral healthcare directory includes the following information for behavioral healthcare practitioners and providers: 1. Name. 2. Specialty. 3. Hospital affiliations. 4. Medical group affiliations. 5. Accepting new patients. 6. Cultural and linguistic capabilities of the practitioner or clinical staff. 7. Office locations and phone numbers. 8. Website address, if applicable. 9. Office or facility accommodations for members with disabilities or special needs. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. 274 File	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
9.9.4	Long-Term Services and Supports Provider Directory Data	Yes	The Delegate has a directory that includes the following information for LTSS providers: 1. Name. 2. Specialty. 3. Hospital affiliations. 4. Medical group affiliations. 5. Accepting new patients. 6. Cultural and linguistic capabilities of the LTSS provider or staff. 7. Office locations and phone numbers. 8. Website address, if applicable. 9. Office or facility accommodations for members with disabilities or special needs. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. 274 File	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11199681AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Contract
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	New Amended and Restated HMO contract
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 10, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11199681AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	
File path for credentialing documentation (new contracts only): G:\Contract Status\Credentialing	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment only, or urgent).

MEDI-CAL

HMO

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

KAISER FOUNDATION HEALTH PLAN, INC.

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

HMO

THIS AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES ("Amended and Restated Contract" or "Contract") is entered by and between Orange County Health Authority, a public agency, dba CalOptima, ("CalOptima"), and **Kaiser Foundation Health Plan, Inc.**, ("HMO"), with respect to the following recitals which are incorporated herein:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein.

D. HMO is an unrestricted full service health care service plan licensed under the California Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code § 1340 et seq.), as amended, that provides health care services to its enrolled Members.

E. CalOptima and HMO originally entered into the Contract for Health Care Services, effective February 1, 2010, (the "Original Contract") and now desire to amend and restate terms and conditions in the Original Contract as set forth in this Amended and Restated Contract.

F. The terms and conditions of this Amended and Restated Contract supersede those in the Original Contract and amendments thereto dated prior to the execution of this Amended and Restated Contract and shall govern the relationship between CalOptima and HMO effective July 1, 2019.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the HMO and are required to discharge the obligations and meet the

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requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.

1.8 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or HMO.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforce applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, HMO, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Health Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the HMO by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed

Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi- Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in applicable MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or from one Health Network to another Health Network; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq. that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 Intentionally Left Blank.

1.23 Intentionally Left Blank.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the programs (including, without limitation, the compliance manual, code of conduct and HMO policies and applicable CalOptima Policies) developed and adopted by HMO and CalOptima to promote, monitor and ensure that CalOptima's and HMO's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and HMO. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on HMO, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider, which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network regardless of Health Network reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the HMO for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the HMO(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 United States Code (USC) Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act") and who is signatory to this Contract.

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or a health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act), which is owned or operated by HMO or with which HMO has a Subcontract to provide Covered Services under this Contract.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Kaiser System" means those providers operating through the Kaiser Foundation hospitals, HMO and the Southern California Permanente Medical Group."

1.52 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.53 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of HMO which impact CalOptima Members.

1.54 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.55 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.56 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.57 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.58 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.59 "Medical Screening Examination" or "MSE" means an examination within HMO's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.60 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.61 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.62 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD) as defined in Title XVIII of the Federal Social Security Act.

1.63 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and the HMO.

1.64 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.65 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements, including but not limited to the Coordination and Provision of Public Health Care Services Contract.

1.66 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.67 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.68 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled in the HMO.

1.69 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with HMO to provide Covered Services to Members.

1.70 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.71 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of HMO. All Participating Providers shall be considered Subcontractors.

1.72 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.73 "Pediatric Preventive Services" or "PPS" means well child services, which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.74 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.75 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.76 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.77 Not Applicable to this Contract.

1.78 "Physician Incentive Plan" means any compensation arrangement between HMO and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.79 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.80 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.81 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.82 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.83 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.84 Intentionally Left Blank.

1.85 "Alcohol Misuse Screening and Counseling" or "AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

1.86 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing.

1.87 Not Applicable to this Contract.

1.88 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes

1.89 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.90 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.91 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.92 "Specialty Mental Health Services" means:

1.92.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.92.2 Psychiatric inpatient hospital services;

1.92.3 Targeted Care Management services;

1.92.4 Psychiatrist services;

1.92.5 Psychologist services; and

1.92.6 EPSDT supplemental specialty mental health services.

1.93 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.94 "State" means the State of California.

1.95 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.96 "Subcontract" means a written agreement entered into by the HMO with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

1.97 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with HMO. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with HMO to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

1.98 "Sub-delegation" means the process by which HMO expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by HMO in order to meet its obligations under, and the intent of this Contract.

1.99 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.100 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.101 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.102 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of HMO – Financial

2.1 Not Applicable to this Contract.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion

2.3 INSURANCE REQUIREMENTS:

2.3.1 Professional/Medical Malpractice:
Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

Hospital providing covered services:
$5,000,000 per incident/$5,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:

HMO shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on HMO's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
HMO and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:
HMO shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Insurer Ratings: Such insurance shall be provided by an insurer:
(a) rated by A.M. Best with a rating of A V or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured: Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change: The HMO shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by HMO shall be provided to CalOptima prior to execution of the Contract and annually thereafter. HMO shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT---HMO shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 Not Applicable to this Contract.

2.6 SKILLED NURSING FACILITY FINANCIAL RESPONSIBILITY --- HMO shall be financially responsible for Skilled Nursing Facility services daily rate when such services are determined by CalOptima to be in-lieu of acute hospitalization.

2.7 PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - HMO and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which HMO receives payment from CalOptima.

2.7.2 Claims Turnaround Time - HMO shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested by HMO, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, HMO shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima

Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from HMO's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of HMO

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of HMO, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that HMO fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from HMO for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce HMO Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of HMO, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 HMO shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 HMO shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 HMO's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are

the financial responsibility of the HMO group. HMO will receive misdirected claims per CalOptima Policy.

2.7.9.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHCs Payments - If FQHC, HMO shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - HMO shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. HMO shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in HMO's provider network, HMO shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy.

2.7.13 Family Planning Provider Payments - HMO shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. HMO may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to HMO along with billing information.

2.7.15 HIV Testing and Counseling Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall provide reimbursement only if local health departments and non-contracting family

planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to HMO.

2.7.16 Information Disclosures To Participating Providers. HMO shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments-

2.7.17.1 Not Applicable to this Contract.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by HMO and the physician and surgeon.

2.7.17.3 For CCS neonatal intensive care units, HMO shall pay the CCS Provider either the equivalent of Medi-Cal fee-for-service rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or HMO's negotiated rates, whichever is higher, for up to 12 months after the transition.

2.7.18 PROPOSITION 56 SUPPLMENTAL PAYMENTS--- CalOptima and HMO shall administer the Medi-Cal Provider Special Supplemental Payment Program, funded by Proposition 56 funds, in accordance with Attachment E-2 to the Contract.

2.7.19 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- HMO shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party,

recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall inform CalOptima of potential third party liability claims and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- HMO shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by HMO and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall HMO cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. HMO shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. HMO shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS, or in child support enforcement cases. If HMO does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then HMO shall follow the procedure above for cost avoidance. If HMO does not reimburse a Provider on a Fee-for-Service basis, then HMO shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 HMO shall have written policies implementing these requirements.

2.9.4 HMO shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 HMO shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 HMO shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 HMO shall demonstrate to CalOptima that where HMO does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues HMO projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 Not Applicable to this Contract.

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- HMO shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care.

2.12 COOPERATION WITH DMHC --- HMO shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to HMO. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of HMO - Administrative

3.1 STATUTORY REQUIREMENTS --- HMO shall retain at all times during the period of this Contract a valid Knox-Keene license issued by the California Department of Managed Health Care (DMHC).

3.2 EQUAL OPPORTUNITY

3.2.1 HMO and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. HMO and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and

selection for training, including apprenticeship. HMO and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state HMO and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 HMO and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of HMO and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 HMO and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of HMO and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 HMO and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 HMO and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State

and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of HMO and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and HMO and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 HMO and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. HMO and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event HMO and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, HMO and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- HMO shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- HMO shall not display the CalOptima logo on any of HMO's written communication to Members without prior written approval by CalOptima.

3.5 MEMBER INQUIRIES AND CALLS --- HMO shall establish and maintain a call center for receiving and responding to Member inquiries and calls. HMO's call center

shall meet requirements established by CalOptima Policies. HMO shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure HMO shall supply reports of call center performance as required by CalOptima Reporting Policy or otherwise required by DHCS.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, HMO shall ensure that all written Member information provided by HMO to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. HMO shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Member grievances. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES. Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, HMO may sub-delegate to an MSO, medical group, and/or IPA Administrative Services required of HMO but shall not absolve HMO of oversight responsibilities. All sub-delegation must be approved by CalOptima. HMO shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. HMO's Sub-delegation to another entity does not alter HMO's ultimate obligation and responsibilities set forth in this Contract. HMO may give a sub-delegate the authority to act on behalf of HMO; but HMO retains oversight and accountability for the sub-delegated Administrative Services. Accountability means that HMO cannot abdicate responsibility for the Administrative Services being performed according to the requirements of this Contract, HMO's standards and those established by this Contract

and CalOptima Policies. HMO is accountable for all Administrative Services performed in its purview whether by HMO, by any sub-delegate or by any sub-sub-delegate. If HMO chooses to sub-delegate an Administrative Service, HMO must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, HMO shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the HMO and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated Administrative Services;

3.8.1.2 The responsibilities of the HMO and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the HMO evaluates the sub-delegate entity's performance; and

3.8.1.5 The HMO's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the HMO's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated Administrative Services, including the entity's score on a selection tool (if any).

3.8.3 A record of the HMO's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The HMO's annual evaluation of whether the entity is performing the sub-delegated Administrative Services in accordance with this Contract and NCQA standards;

3.8.3.2 The HMO's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 HMO shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 HMO shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of HMO's Members, including those receiving services from a sub-delegate of HMO.

3.8.6 HMO shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve- (12) month period. HMO shall establish standards and performance requirements for sub-delegate Administrative Service(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of HMO in this Contract and in CalOptima Policies. HMO may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group, or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by HMO to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. HMO shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. HMO shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- HMO may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. HMO is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. HMO is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. HMO shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI and CMS requirements for reporting information about Offshore Subcontracts. HMO shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, HMO shall require all Subcontracts contain the following:

3.9.1 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements under applicable State and federal law and regulatory guidance, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10, and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or HMO, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 Subcontractor's agreement to provide HMO with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to Members in a non-discriminatory manner;

3.9.8 If applicable, an agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or change to a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program and HMO's Compliance Program including, without limitation, CalOptima

Policies and HMO policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;

3.9.11 As applicable, an agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, a copy of which is attached as Attachment D or a similar HMO form acceptable to DHCS which complies with the State Contract, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event HMO cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with HMO and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract, for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract;

3.9.15 In the event that HMO implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by HMO.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and

construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if HMO delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or HMO determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the HMO to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 HMO ORGANIZATION AND OPERATIONS STRUCTURE --- HMO shall comply with the organization and operations structure requirements of applicable laws and regulations. Without limiting the foregoing, HMO shall maintain a full time physician as Medical Director/Chief Medical Officer (CMO) whose responsibilities shall include, but not limited to, the following:

3.10.1 Ensuring that medical decision are: (i) rendered by qualified medical personnel, and (ii) are not unduly influenced by fiscal or administrative management considerations.

3.10.2 Ensuring that the medical care provided meets the standards for acceptable medical care.

3.10.3 Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

3.10.4 Developing and implementing medical policy.

3.10.5 Resolving grievances related to medical quality of care.

3.10.6 Direct involvement in the implementation of Quality Improvement activities.

3.10.7 Actively participate in the functioning of the grievance and appeal procedures.

3.11 ENROLLMENT --- HMO shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to HMO. HMO and CalOptima understand and agree that individuals who become eligible for CalOptima may only be assigned to HMO if those individuals, their spouses or domestic partners, parents, guardians, minor children, minor siblings, or disabled dependents are enrolled in HMO or have been enrolled in HMO during the previous twelve (12) months.

3.12 PCP ASSIGNMENT --- HMO shall assign Members who have been automatically assigned to HMO by CalOptima to a PCP within seven (7) days of the Member's assignment to HMO.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- HMO shall mail to a Member or Member's head of household a notice of enrollment and a HMO Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with HMO. All member handbooks and supplements prepared by HMO shall be submitted to CalOptima for approval prior to printing. HMO shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should HMO choose to utilize the CalOptima Member handbook, HMO-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all HMOs' CalOptima Members. CalOptima shall provide HMO with a template for the supplement to the CalOptima member handbook.

3.13.2 If HMO chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, HMO's Member handbook shall contain the topics required to be included by

the DHCS and be modeled on the DHCS Member Handbook template. Any deviations from the DHCS template shall be subject to review by CalOptima.

3.13.3 HMO shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. HMO shall also provide one (1) copy of its enrollment information including its HMO Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- HMO may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- HMO shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- HMO shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). HMO shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site.

3.17.1 HMO and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. HMO shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical Records under this Section shall reflect all aspects of patient care, including ancillary services.

3.17.3 It is understood that all Participating Provider's and Subcontractors' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at HMO's, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the HMO's, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- HMO and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, with the exception in which HMO or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 HMO shall, upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any

monitoring, inspection or evaluation is made of the premises of HMO or Subcontractor, HMO shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, HMO shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the HMO's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, HMO shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by HMO and Subcontractors pertaining to these services at any time pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, HMO shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at HMO's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the HMO's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of HMO's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of HMO, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for

any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to HMO. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and HMO will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period as specified in Section 3.18, HMO and Subcontractors shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to HMO's provision of and reimbursement for activities contemplated under the Contract, and to HMO's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign HMO's statement of confidentiality prior to being admitted access to HMO's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the HMO at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; seek recovery of payments made to the HMO; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, HMO shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document

production requests, or requests for records, received by HMO or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 HMO further agrees to timely gather, preserve, and provide to DHCS any records in the HMO's or its Subcontractors' possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- HMO and Subcontractors shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out-of-Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, HMO shall keep CalOptima informed as to the names of the officers and owners of HMO holding more than five percent (5%) of the stock issued by HMO, and major creditors holding more than five percent (5%) of the debt of the HMO. HMO shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If the provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, HMO shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- HMO shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or HMO's employees, within five (5) working days of the date when HMO first becomes aware of or is on notice of such activity.

3.24.1 Intentionally Left Blank.

3.24.2 HMO shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 HMO shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- HMO shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the HMO's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 HMO COMPLIANCE PROGRAM --- HMO shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the HMO annually to ensure that it remains effective. HMO shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH COMPLIANCE PROGRAM --- HMO and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("HMO's Agents") shall comply with the requirements of Compliance Program, as may be amended from time to time.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- HMO shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. HMO's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- HMO agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. HMO acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- HMO agrees to comply with and be bound by

any and all applicable MOUs entered into by CalOptima. HMO agrees to require Subcontractors to comply with applicable requirements of such MOUs.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS ---HMO shall have policies and procedures to verify the Participation Status of HMO's Agents. HMO shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, HMO warrants and agrees as follows:

3.31.1 HMO and HMO's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 HMO shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by HMO or HMO's Agents occurring and/or discovered during the term of this Contract.

3.31.3 HMO shall take immediate action to remove any HMO Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 HMO shall ensure Subcontractors comply with the requirements of this Section.

3.31.5 CalOptima and HMO, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. HMO shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, and et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, and et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a

part hereof as if set forth in full. HMO and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 HMO and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the HMO nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 HMO shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with

disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 HMO shall act upon all complaints alleging discrimination against Members in accordance with HMO's policy which shall be consistent with CalOptima's Complaints of Discrimination Policy.

3.32.5 HMO shall require all downstream providers to cooperate with HMO's policy which shall be consistent with CalOptima's Complaints of Discrimination Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. HMO shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 HMO shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. HMO shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. HMO shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. HMO shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, HMO shall provide translation of written member informing materials in the Threshold and Concentration Languages. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, HMO shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. HMO shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. HMO shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.33.3 HMO shall require that all Participating Providers comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04.

3.34 PROVISION OF INTERPRETERS --- HMO shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by HMO or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. HMO shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. HMO shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, HMO must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. HMO shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's Medical Record. This documentation shall be available to CalOptima at CalOptima's request. HMO shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. HMO shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- HMO shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. HMO shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- HMO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 HMO and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future, within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 HMO shall comply with HIPAA requirements as currently established in HMO policies and the Business Associate Agreement between CalOptima and HMO. HMO shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Health Network HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 HMO and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to HMO, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract. HMO and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima

without prior written authorization from CalOptima. For purposes of this provision, identity shall include, Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with applicable law pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by HMO or its Subcontractors, HMO:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the HMO by DHCS for this purpose.

3.39 Not Applicable to this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- HMO shall have a process for claims management and administration. HMO shall maintain a claim

retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. HMO shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE--- HMO shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider's or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the HMO being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. HMO shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- HMO acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). HMO shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between

HMO and CalOptima pursuant to which HMO agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- HMO shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. HMO shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of HMO's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- HMO shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 HMO SUBCONTRACTS --- In addition to Section 3.9 of this Contract, HMO shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. HMO shall ensure that all Subcontracts are in writing and require that the HMO and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – HMO understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of HMO under this Contract. In instances where DHCS or CalOptima determines that the HMO or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the HMO, (b) require the HMO to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. HMO shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of HMO or the oversight of those obligations.

3.47 POLICY CHANGE REVIEW PROCESS

3.47.1 HMO may submit to CalOptima proposed changes and/or exemptions to CalOptima policy requirements where HMO asserts such changes and/or exemptions are necessary to address HMO's unique integrated model and operation as a full-service health plan. HMO shall submit the requested

changes and/or exemptions in writing to CalOptima's Health Network Provider Relations. Such requests shall be accompanied by information regarding the specific issue that HMO asserts supports the requested change and/or exemption.

3.47.2 CalOptima's Health Network Provider Relations will review each request and seek input from CalOptima operational departments as it deems necessary and appropriate. HMO acknowledges that the CalOptima Board of Directors must approve proposed changes and/or exemptions to CalOptima policies. CalOptima's Health Network Provider Relations will notify HMO in writing whether or not the proposed change or exemption will be presented to the CalOptima Board of Directors for approval. HMO acknowledges and agrees that CalOptima has the sole discretion to accept, reject or modify any requested policy change and/or exemption. HMO also acknowledges and agrees that CalOptima, including its Health Network Provider Relations Staff, has no obligation to present any proposed policy changes and/or exemptions to the CalOptima Board of Directors for approval.

3.47.3 If the CalOptima Board of Directors approves proposed changes and/or exemptions to CalOptima policies for HMO that create a conflict with any provision in this Contract, the revised CalOptima Policy shall govern.

ARTICLE 4
Obligations of HMO – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- HMO shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of HMO, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that HMO is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, HMO shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. HMO shall provide Covered Services to Members and HMO agrees as follows:

4.1.1 HMO shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of HMO as set forth in Attachment A.

4.1.2 If HMO's network is unable to provide necessary medical services covered under this Contract to a particular Member, HMO must adequately and timely cover these services out-of-network for the Member, for as long as HMO is

unable to provide them. HMO shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 HMO shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective HMO as to the Medical Necessity of the service, except that HMO shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 HMO shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the HMO denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. HMO acknowledges that disputes between the respective HMO and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 HMO shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or HMO, CalOptima's or the HMO's insolvency, or breach of this Contract by the HMO or CalOptima, shall HMO or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit HMO or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract

or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. HMO or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's Medical Record. HMO further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the HMO and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the HMO's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the HMO and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 HMO further agrees that, in the event of a violation of this Section by HMO or Subcontractor, including but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against HMO or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- HMO shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). HMO is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 HMO shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if HMO reasonably determines that Emergency Services were never performed.

4.2.2 HMO shall reimburse or authorize reimbursement for facility changes for Emergency Services. HMO is required to reimburse hospital when necessary

for all MSE. If the MSE indicates that the Member has an Emergency Medical Condition as defined in Section 1.34, HMO must reimburse or authorize reimbursement, as appropriate for all Covered Services Medically Necessary to diagnose and Stabilize the Member.

4.2.3 HMO shall reimburse those physicians providing services in an Emergency Department with whom HMO has a contract according to the terms of that contract. HMO shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. HMO shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, HMO shall not deny payment for treatment obtained when HMO or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 HMO shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between HMO or any Participating Provider and Out-of-Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider and Hospital under contract with HMO agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on HMO.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). HMO is financially responsible for post-stabilization services obtained within or outside HMO's network that are pre-approved by a plan provider or other entity representative. HMO is

financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other HMO representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to HMO for pre-approval of further post-stabilization care services.

4.2.8.1 HMO is also financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if HMO does not respond to a request for pre-approval within 30 minutes; HMO cannot be contacted; or HMO's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, HMO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 HMO's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214 HMO is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Section, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Section shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section shall constitute payment in full under this Section, and shall not be subject to subsequent adjustments or reconciliations by HMO, except as provided by Medicaid and Medi-Cal law and

regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by HMO pursuant to this Section.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, HMO is financially responsible for payment for post-stabilization services following an emergency admission. HMO shall reimburse those physicians providing post-stabilization services with whom HMO has a contract according to the terms of that contract. HMO shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- HMO shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- HMO is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. HMO service locations shall adhere to the confidentiality of Member's Family Planning information and records. Notwithstanding the foregoing, HMO shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. If HMO subcontracts with PCPs, such Subcontracts must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services shall not be required.

4.4.1 HMO shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires HMO to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out-of-Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve HMO from financial responsibility for such services.

4.4.2 HMO shall not prevent Members from receiving Family Planning Covered Services from Out-of-Network Providers.

4.4.3 HMO shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. HMO shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 HMO shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with HMO policies which shall be consistent with CalOptima Policies, for any reason including if the Member has reason to believe that the HMO has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 HMO shall incorporate specifications of this Section or substantially similar specifications in its Subcontracts with its PCPs (if HMO subcontracts with PCPs) and with its obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- HMO shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH HMO OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, HMO shall arrange for the timely referral and coordination of Covered Services to which HMO or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL MISUSE SCREENING AND COUNSELING --- HMO shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network physician without first requesting a referral from a network Primary Care Physician. HMO shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within HMO's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- HMO acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify HMO of the date upon which HMO will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time HMO shall commence all CalOptima WCM obligations.

4.10 COMMUNITY BASED ADULT SERVICES

4.10.1 HMO will provide Community Based Adult Services (CBAS) to include outpatient programs that deliver skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91, to eligible Members who meet applicable eligibility criteria.

4.10.1.1 HMO shall require CBAS services to include all of the following:

- Skilled nursing care
- Therapeutic activities
- Social services
- Personal care
- Therapies (physical, occupational and speech)
- Mental health services
- Registered dietitian services
- Family/caregiver training and support
- Meals at the CBAS center
- Transportation to and from the CBAS center

4.10.1.2 HMO shall document the initial assessment for CBAS eligibility and provide the following clinical documents to CalOptima, including those documented by CBAS Providers:

- Initial assessment for CBAS eligibility
- 6-month reassessments for CBAS eligibility
- Quarterly progress notes
- Individual Plan of Care (IPC)
- Discharge plan

4.10.1.3 Assessment and Reassessment Community Based Adult Services. HMO shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements

- HMO shall ensure all staff responsible for conducting an initial assessment or reassessment of Members for CBAS shall receive training from CalOptima on using the approved assessment tool.

- HMO shall conduct the initial assessment of a Member requesting CBAS using the assessment tool approved by DHCS. Initial assessments shall include a face-to-face review of the Member when chart documentation of a Member's condition is insufficient. HMO shall include a registered nurse with level of care experience and a social worker on the assessment team, either as an employee or as a sub-contractor.

- HMO shall develop and implement and expedited assessment process to determine CBAS eligibility for Members in a hospital or skilled nursing facility whose discharge plan includes CBAS, or who are at high risk of, admission to a skilled nursing facility.

- HMO shall reassess Member eligibility for CBAS no sooner than six (6) months after initial Member eligibility has been determined or the last reassessment, whichever is later or upon a change in circumstances requiring and increased level of CBAS.

- If Member is already receiving CBAS and requests that services remain at the same level, HMO may conduct the reassessment using only Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

- HMO shall not deny, defer, or modify a requested level of CBAS without a face-to-face review per the assessment tool approved by DHCS. An IPC, or any other form of documentation, shall be deemed insufficient by DHCS to deny, defer, or modify a requested level of CBAS.

- HMO shall notify Members in writing of the CBAS assessment determination in accordance per DHCS regulation.

4.10.1.4 HMO shall furnish Members who have been determined to no longer need CBAS with a Discharge Plan

- Discharge Plan means a plan of care given to Members who have been determined to no longer need CBAS and must include:
- The Member's name and ID number
- The name(s) of the Member's physician(s)
- The date the Notice of Action was issued
- The date CBAS will end
- Specific information about the Member's current medical conditions, treatments, and medications
- A statement of how Complex Case Management and Person-Centered Planning services will be provided to the Member
- A statement of the Member's right to file a Grievance or Appeal
- A space for the Member or the Member's representative to sign and date the Discharge Plan

4.10.1.5 HMO shall submit reports related to CBAS as required by CalOptima Reporting Policy or otherwise required by DHCS.

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ARTICLE 5
Obligations of HMO – Access

5.1 TWENTY FOUR (24) HOUR PHYSICIAN COVERAGE --- HMO shall ensure that a physician Participating Provider or physician employed by HMO is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, HMO shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies.

5.2 URGENT CARE SERVICES --- HMO shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- HMO shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment, and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. HMO shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. HMO's failure to perform at or in excess of minimum performance requirements shall subject HMO to sanctions in accordance with Article 13 of this Contract and CalOptima Policies. HMO shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- HMO shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements.

Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 HOSPITAL GEOGRAPHIC DISTRIBUTION --- HMO agrees that each hospital participating in the HMO, shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services - HMO shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. HMO shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – HMO shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. HMO shall arrange for the provision of specialty services from specialists outside the network if unavailable within HMO's network, when determined medically necessary.

5.6.3 Preventive Covered Services - HMO shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services - HMO shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. HMO shall cover and ensure the provision of all Medically Necessary services for pregnant Members. HMO shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement - HMO shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards

of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization– within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements.

5.7 OFFICE WAITING TIMES --- HMO shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- HMO shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in HMO policies which shall be consistent with CalOptima Policies. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. HMO's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. HMO's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- HMO shall give Members thirty (30) calendar days' notice if their PCP withdraws from HMO. All template notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by HMO. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within HMO for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- HMO shall offer each Member the opportunity to choose a PCP affiliated with the HMO. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When HMO receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, HMO shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in HMO. HMO shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, HMO shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, HMO shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;

5.13.1.2 Total physicians 1:1,200 Members; and

5.13.1.3 If Non-physician Medical Practitioners are included in HMO's Network, each individual Non-physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - HMO shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Two (2) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- HMO shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- HMO shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Upon request, HMO shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence.

5.16 PHYSICAL ACCESS --- HMO's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- HMO shall ensure that HMO's provider directory is in compliance with SB 137 and updated when either of the following occur:

5.17.1 The Provider is not accepting new Members.
5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members.

ARTICLE 6
Obligations of HMO – Clinical Quality

6.1 LICENSURE --- HMO shall ensure that every physician providing Covered Services and employed or engaged by HMO or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- HMO shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Agreement. HMO shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- HMO shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- HMO shall participate and cooperate in CalOptima's Quality Improvement Program. HMO shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). HMO shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. HMO shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of HMO or a multi-disciplinary QI Committee designated by the Board of Directors of HMO shall oversee the QI Program conducted by HMO. This committee shall be separate from the Utilization Review committee (though Members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from HMO. The QI Committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 The HMO's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima, if applicable.

6.4.7 HMO shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or the HMO; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the HMO's QI Program shall be established by the HMO's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI Program. HMO shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 HMO shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, HMO

shall make available summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 The HMO shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 HMO shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- HMO shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 HMO shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 HMO Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review HMO's Case Management Services program to determine compliance with Case Management Services standards. HMO shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 HMO Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, HMO shall assure that HMO possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF HMO UPON TERMINATION OF CONTRACTED PROVIDERS --- HMO shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site and assisting them in selecting a new PCP or PCP site. HMO shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a new PCP or PCP site. HMO shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. HMO shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or HMO decides to terminate the contract for

reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with HMO, but the rest of the group continues its contract with HMO, then HMO shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2^{nd}) or third (3^{rd}) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, HMO shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by HMO's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, HMO shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- HMO shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment, HMO shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. HMO's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. HMO must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, HMO may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated HMO shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated HMO shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- HMO shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations.

Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, HMO shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 HMO shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, HMO shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 HMO shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by HMO, HMO remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), HMO must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the

transition. At its discretion, HMO may extend the continuity of care period beyond the 12 months specified in this Section

6.7.5.2 For out-of-network CCS Providers and Providers of Specialized Durable Medical Equipment, HMO must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts HMO's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by HMO and the CCS Provider.

6.7.5.2.3 HMO confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to HMO, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, HMO and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, HMO shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, HMO shall

apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. HMO shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 HMO shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through HMO's assessment. To arrange services with a regional center, HMO shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 HMO shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in

collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, HMO shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, HMO shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition HMO for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if HMO denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 HMO must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.7.9 ADMINISTRATIVE SERVICES PROVIDED FOR CCS

6.7.9.1 HMO shall provide all administrative services specified in this Contract and the Health Plan Quality Delegation Agreement for CCS-eligible Members.

6.7.9.2 CalOptima shall provide a monthly administrative capitation payment to HMO, as stated in Attachment E, for enrolled CCS-eligible members following the regular Medi-Cal Capitation process and timeline.

6.8 CREDENTIALING REQUIREMENTS --- HMO acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to HMO. HMO shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Agreement. HMO shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 HMO shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 HMO shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. HMO shall ensure that any Participating Provider who

is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. HMO shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 HMO shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 If applicable, Quarterly Summaries and copies of facility site reviews performed for PCPs.

6.9 BOARD CERTIFICATION --- HMO shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 HMO shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. HMO shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination

of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 HMO acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with HMO to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW --- HMO shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS, unless exempted by CalOptima. HMO shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- HMO shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 HMO shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the HMO.

6.11.4 HMO shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 HMO shall be responsible for coordinating care of certain services including:

6.11.8.1 HMO's Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 HMO shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 HMO shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC);

6.11.8.5 HMO shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 HMO shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 HMO shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. HMO shall develop referral and prior authorization policies and procedures to implement the above requirements. HMO shall submit these policies to CalOptima for review and approval;

6.11.8.9 For HMO Members requiring Specialty Mental Health Services, HMO shall refer Members to the Administrative Services Organization (ASO) contracted by the County of Orange to provide assessment, referrals and authorization for Specialty Mental Health Services.

6.11.8.9.1 For HMO Members referred for Specialty Mental Health Services, HMO shall provide Care

Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. While DHCS retains responsibility for certain psychotherapeutic drugs, HMO shall retain financial responsibility for laboratory tests associated with the provision of behavioral health services, including, but not limited to, those associated with the use of psychotherapeutic drugs. HMO shall comply with all responsibilities, policies and procedures set forth in the HCA/MHP MOU.

6.11.8.9.2 For HMO Members receiving inpatient Specialty Mental Health Services, HMO shall retain financial responsibility for the initial physical health assessment (medical history and physical exam) for any Member admitted to an inpatient mental health facility. This assessment shall be performed by a facility physician or the Member's PCP. HMO shall remain financially responsible for and shall coordinate, if notified, non-mental health services required by a Member while undergoing inpatient psychiatric treatment, including, but not limited to, x-rays and laboratory services.

6.11.8.10 For Member requiring alcohol or other substance use disorder services, HMO shall refer Members to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS). However, for Members requiring outpatient heroin detoxification, HMO shall refer the Member to an appropriate Provider.

6.11.9 To the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use it as the HMO is able for the purpose of Member care coordination.

6.12 VACCINES --- HMOs shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with HMO's immunization policy. CalOptima shall not reimburse HMO for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 OUTPATIENT MENTAL HEALTH SERVICES ---

6.13.1 HMO's PCPs shall provide Outpatient Mental Health Services within the scope of their practice.

6.13.2 For Outpatient Mental Health Services outside the PCP scope of practice, HMO shall refer Members to appropriate behavioral health Providers.

6.14 RESEARCH --- HMO agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF HMO FOR SPD --- HMO shall provide the following for SPD Members:

6.15.1 Intentionally Left Blank.

6.15.2 HMO shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 HMO shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. HMO shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 HMO shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) HMO determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period;

6.15.5 HMO or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. HMO shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, HMO shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the HMO;

6.15.6 HMO shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. HMO shall provide to all SPD Members upon enrollment HMO and at any time thereafter, upon the SPD Member's request a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment in the HMO of an SPD Member, HMO shall complete a plan of care pursuant to CalOptima Policies. HMO shall update this plan as appropriate and/or annually. HMO shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies, HMO shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 HMO shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 HMO shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If HMO's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, HMO must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. HMO acknowledges that Out-of-Network Providers must coordinate with HMO with respect to payment, and HMO shall ensure that such Out-of-Network Providers understand this requirement. HMO must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. HMO shall provide for the completion of covered services by a terminated or Out-of-Network Provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, HMO shall provide continued access for up to twelve (12) months to an Out-of-Network Provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom

they are receiving services), if the provider will accept HMO or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an Out-of-Network Provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, HMO shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 HMO and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by HMO pursuant to DHCS requirements and CalOptima Policies.

6.16 ADVANCE DIRECTIVES --- HMO shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. HMO shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- HMO shall provide, at its sole cost and expense second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- HMO shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- HMO shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. HMO shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- HMO shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. HMO shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, HMO and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of HMO – Reporting

7.1 DATA REPORTING REQUIREMENTS --- HMO shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. HMO shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- HMO shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's regulators as provided in this Contract and in CalOptima Policies. HMO shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; HMO shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that HMO is reporting to CalOptima less than all professional and facility encounters in the CalOptima required format and timelines. HMO shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- HMO agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred-twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Members. HMO shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If HMO is required to file monthly Financial Statements with the DMHC, HMO shall simultaneously file monthly Financial Statements with DHCS. HMO shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. HMO shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- HMO shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting HMO's provider network.

7.6 HMO ORGANIZATION PROFILE --- HMO shall report in compliance with CalOptima Policies, a profile of the HMO's organization, including, but not limited to, HMO's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- HMO shall provide to CalOptima copies of all contract templates utilized with Subcontractors for purposes of fulfilling HMO's obligations under this Contract. Upon modification, change or replacement by HMO, HMO shall provide CalOptima with copies of current contract templates entered into or amended for purposes of fulfilling HMO's obligations under this Contract.

7.8 DISCLOSURE --- HMO and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of HMO's or Subcontractor's financial records related to HMO's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that HMO, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – HMO shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meets its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, HMO shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by HMO to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the HMO's letterhead signed by the HMO's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of HMO – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that HMO shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of HMO at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which HMO received Capitation Payment and termination occurred, HMO shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the HMO shall make available to DHCS and/or CalOptima copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible,

of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 HMO agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by HMO.

8.3 TERMINATION PLANS --- HMO shall have a plan for the orderly termination of services under this Contract. HMO shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- HMO acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and HMO shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. HMO acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 NOTICE TO THE DEPARTMENT OF MANAGED HEALTH CARE -- In addition, HMO shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, which represents a pass-through of rates determined and paid by DHCS, less allowed administrative fees, by the number of Members enrolled with HMO.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to HMO on or about the fifteenth (15th) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with HMO.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from HMO an amount equal to [redacted] of the monthly Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment on a quarterly basis should the Withhold fall below [redacted] of HMO's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the HMO. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 Not Applicable to this Contract.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- HMO has an obligation to report any overpayment under this Contract by CalOptima identified by HMO, and to repay such overpayment to CalOptima within sixty (60) days of such identification by HMO, or of receipt of notice of an overpayment identified by CalOptima. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO, after giving HMO notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from HMO to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by HMO to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.
9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to HMO's capitation
9.4.6 Payments made by CalOptima that are the financial responsibility of HMO.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of HMO paid by CalOptima against any funds owed to HMO by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or HMO additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay HMO any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by HMO.

9.8 Not applicable to this Contract

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- HMO shall arrange and pay for dialysis services for Members with End-Stage Renal Disease (ESRD).

9.12 FALSE CLAIMS ACT POLICY – Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

9.13 REIMBURSEMENT FOR CCS-ELIGIBLE MEMBER SERVICES

9.13.1 HMO shall submit a monthly report in a format as agreed by CalOptima and HMO for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members. HMO shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by Cal Optima and HMO.

9.13.2 CalOptima shall validate and reprice the submitted claims as follows:

9.13.2.1 Internal HMO Pharmacy claims, shall be reimbursed at the equivalent of [redacted] of the CalOptima contracted Pharmacy Network rate; and

9.13.2.2 Physician, Hospital and Ancillary HMO Kaiser System claims, shall be reimbursed at the equivalent of [redacted] of the CalOptima Medi-Cal fee schedule. CalOptima updates the CalOptima Medi-Cal fee schedule on a monthly basis which is effective the first of the following month. Reimbursement will be based on the CalOptima Medi-Cal fee schedule in effect on the date of service;

9.13.2.3 Professional services provide by Kaiser System CCS-paneled Providers shall be reimbursed at [redacted] of the CalOptima Medi-Cal fee schedule; and

9.13.2.4 For non-Kaiser System pharmacy and other services, CalOptima shall reprice the claims at the rate paid by HMO under its contract with the provider, or the rate negotiated and paid by HMO. HMO may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

9.13.3 Repricing Results and Reconciliation

9.13.3.1 CalOptima shall notify HMO of the results of the repricing within 30 business days after the date of CalOptima's receipt of the complete claims paid file.

9.13.3.2 HMO shall provide a rebuttal to, or acceptance of, the results within 30 business days after the date or receipt of the results.

9.13.3.3 CalOptima, with the cooperation of HMO, shall perform a reconciliation of paid covered service expenses, if necessary.

9.13.3.4 CalOptima shall issue payment to HMO within 15 business days after receipt of the repricing acceptance or the completion of the reconciliation.

9.13.3.5 In the event that HMO is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then HMO shall be entitled to pursue the matter through the provider dispute process.

9.14 SPECIAL SUPPLEMENTAL REIMBURSEMENTS. Notwithstanding sections 9.13, Hepatitis C drug therapy or Behavioral Health Therapy (BHT) services provided to

CCS-Eligible Members shall be reimbursed at the same supplemental rates at which such services are reimbursed for all other HMO Members.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 Not Applicable to this Contract.

10.2 COMPREHENSIVE HMO AUDIT --- CalOptima shall conduct and HMO shall agree to a full comprehensive compliance audit to be conducted at HMO administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the HMO audit in writing to the HMO. HMO may rebut and dispute audit findings pursuant to CalOptima Policies. HMO is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. HMO acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from HMO.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each HMO's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the HMO accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current MOUs entered into by CalOptima that are binding on HMO within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on HMO may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for HMO interpretation of MOUs entered into by CalOptima that are binding on HMO. Interpretation of MOUs will identify duties, obligation and responsibilities of HMO.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- HMO acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to HMO, information and data relating to the performance of HMO that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and HMO shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. HMO complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to HMO the amount of capitation payments from DHCS that are used to derive the capitation rates specified in Attachment F, to be paid per member per month. HMO shall not disclose any proprietary DHCS rates that may have been shared with HMO for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to HMO, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets,

including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to HMO the amount of capitation payments from DHCS that are used to derive the capitation rates specified in Attachment F, to be paid per member per month. HMO shall not disclose any proprietary DHCS rates that may have been shared with HMO.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to HMO sufficient details to allow HMO to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all HMO, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF HMO TERMINATION PLANS --- CalOptima shall review and approve HMO termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release HMO's capitation withhold to HMO upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by HMO of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination,

CalOptima may, at its sole discretion, apply HMO's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 Not Applicable to this Contract.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- HMO may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the HMO ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 Intentionally Left Blank.

12.3 PERINATAL SUPPORT SERVICES (PSS)

12.3.1 HMO shall provide a PSS program, which shall be consistent with services provided through the California Comprehensive Perinatal Services Program (CPSP), and at a minimum, shall follow the current American College of Obstetrics and Gynecology (ACOG) standards and comply with applicable MOUs and CalOptima Policies. HMO shall offer the PSS program to the perinatal Member within four (4) weeks after the first perinatal visit following the perinatal Member's eligibility with HMO.

12.3.2 HMO shall administer physician's PSS program. PSS shall be provided to a Member participating in the PSS program through HMO's Participating Provider that is either CPSP certified or a PSS Provider that meets the requirements for service provision as set forth in DHCS Policy Letter 12-003 and applicable MOUs.

12.3.3 Member participation in the PSS program is voluntary (Title 22, CCR Section 51348.2). HMO cannot require Member's participation in the PSS program.

12.3.4 HMO shall submit reports related to PSS as required by CalOptima Reporting Policy or otherwise required by DHCS.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If HMO fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Members whose medical condition or history indicated a need for

substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (vii) failure to ensure that all Minimum Standards are met; (viii) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (ix) not having the required amounts and types of financial reserves; (x) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xi) failure to meet Medical Loss Ratio requirements; (xii) failure to meet minimum enrollment requirements; (xiii) failure to meet quality and/or performance requirements; (xiv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in

CalOptima deducting the penalty plus the administrative fee from the HMO's Capitation Payment.

13.1.2.2 HMO may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause - Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. HMO may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. HMO shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, HMO shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of HMO.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the HMO in the event that membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of HMO membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should HMO fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should HMO fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to HMO that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR HMO ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should HMO fail to comply with requirements for HMO's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR HMO INSOLVENCY --- If HMO becomes insolvent, HMO shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against HMO or a principal Subcontractor, HMO shall assure that all HMO's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

13.11 TERMINATION BY HMO FOR CAUSE --- Provided that HMO is not in default hereunder, HMO may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to HMO under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to HMO any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW --- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify HMO in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and

HMO shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO HMO --- CalOptima may establish key performance measures of HMO to set minimum contract performance thresholds and/or pay financial incentives to Health Network. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against HMO, terminate this Contract, and establish Capitation Rates and other payments to HMO.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- HMO agrees as follows:

13.14.1 CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that HMO Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that HMO terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, HMO shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event HMO elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION --- Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF HMO --- CalOptima and HMO agree that HMO and any agents or employees of HMO, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. HMO shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY--- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION --- HMO agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO or Subcontractor; (iii) the merger, reorganization, or consolidation of HMO or Subcontractor with another entity with respect to which HMO or Subcontractor is not the surviving entity; and/or (iv) a change in the management of HMO or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of HMO or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D or similar HMO form acceptable to DHCS which complies with the State Contract, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the HMO agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the HMO certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the HMO is unable to certify to any of the statements in this certification, the HMO shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the HMO knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. HMO further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION -

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure in the form set forth in Attachment F, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed

to make any payment using nonappropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and

the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: HMO
Kaiser Foundation Health Plan, Inc.
Attention: Executive Director, Medi-Cal Contract Management
393 E. Walnut Street, Pasadena, CA 91188

14.18 GOVERNMENT CLAIMS ACT --- HMO shall ensure that HMO and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
SIGNATURES

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS AMENDED AND RESTATED CONTRACT SHALL BE JULY 1, 2019 THROUGH JUNE 30, 2020.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Contract:

FOR HMO:	FOR CALOPTIMA:
George Di Salvo George Di Salvo (Feb 9, 2021 17:18 PST)	
SIGNATURE	SIGNATURE
George Disalvo	Ladan Khamseh
PRINT NAME	PRINT NAME
Chief Financial Officer, Southern California	Chief Operating Officer
TITLE	TITLE
Feb 9, 2021	2/10/2021
DATE	DATE

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ATTACHMENT A (effective 7/1/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the HMO components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the HMO Budget being financially responsible for the provision of Covered Services as indicated in this Division . Kaiser Foundation Health Plan, Inc. is the responsible party for Covered Services designated under "Physician" and "Hospital Budget" columns. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	*- See Transportation -*		
Amniocentesis	X		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc....)			
Professional component	X		
Facility component		X	
Birth Control	*- See Family Planning -*		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	

	Physician	Hospital Budget	Other
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
Community-Based Adult Services (CBAS)	X		
CHDP	*- See Pediatric Preventive Services -*		
Chemotherapy			
Professional Component	X		
Outpatient Facility Component		X	
Medication (see Medication)			
Chiropractic Services	X		
Cosmetic Surgery (Medically necessary)			
Professional component	X		
Facility component (licensed surgical center or acute facility only)		X	
Dental Services			
General dental services - Including teeth			***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)			
-- Professional component	X		
-- Facility component		X	
Anesthesia Services			
-- Professional component (Other than provided by Dentist)	X		
-- Professional component (Provided by Dentist)			***Denti-Cal***
-- Facility component		X	
Detoxification - Medical (inpatient acute medical facility only)			
Professional component	X		
Facility component		X	

	Physician	Hospital Budget	Other
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related supplies & drugs required for the service-example dyes injected for imaging)			
-- Professional and Facility Components	X		
Diagnostic Services (Inpatient), Including Radiology			
Professional Component	X		
Facility Component		X	
Dialysis			
Professional component	X		
Facility component		X	
DOT (Directly Observed Therapy) TB Treatment			***OCHCA***
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		X	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings)	X		
Custom Wheelchair Assessment (excluding those conducted through Medical Therapy Program [MTP])	X		
Custom Wheelchair Assessment through MTP			***OC HCA/ State***
Emergency Room (POS 23) Minor DME(cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		X	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	X		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions, and the technical component of diagnostic testing.		X	
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility			***OC HCA / State***

	Physician	Hospital Budget	Other
EPSDT Services			
Acupuncture	X		
Audiology	X		
Chiropractic	X		
Cochlear Implant	X		
Dental Services			*State*
EPSDT Case Management	X		
Hearing Aid Batteries	X		
In-Home Private Duty Nursing (PDN)	X		
Medical Nutrition Services	X		
Occupational Therapy[1]	X		
Orthodontic Services			*Denti-Cal*
Pediatric Day Health Care Services (through EPSDT or through CCS)			*State*
Speech Therapy	X		
Mental Health - Specialty Outpatient			*OC HCA / State*
Family Planning (including birth control)			
Professional component	X		
Facility component		X	
IUDs	X		
Contraceptive items/supplies and drugs provided by the family planning clinic	X		
Non-Injectable drugs	*- See Medication -*		
Implants/Injections	*- See Medication -*		
Contraceptive items/ supplies	X		
Genetic Disease Screening			
Prenatal Triple Marker Screening			*DHCS Genetic Disease Branch*
Follow-up services for positive prenatal screening			*DHCS Genetic Disease Branch*
Newborn screening panel		X	
Other Genetic Testing/Counseling	X		
Hearing Aids	X		
Hearing Screening	X		

	Physician	Hospital Budget	Other
Home Health Care			
Care for medical conditions		X	
Care for psychiatric conditions			*OC HCA / State*
Injectable medications	*-See Medication -*		
Home infusion	*-See Medication -*		
Home Health and Home Infusion Pumps & Supplies		X	
Hospice Services (ALL levels of services at any facility/location/setting)		X	
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		X	
Psychiatric			*OC HCA / State*
Hyperbaric Oxygen Therapy		X	
Immunizations	*- See Preventive Services -*		
Incontinence Creams and Washes[2]	*X*		
Injectables	*- See Medications -*		
Laboratory Services			
Inpatient - Medical (technical component)		X	
Inpatient – Psychiatric			*OC HCA / State*
Outpatient (Including surgical pathology services)	X		
Emergency	*- See Emergency Services -*		
Long-Term Care Services, including Custodial (Sub-acute, SNF, ICF, ICF/DD, ICF/DD-N, ICF/DD-H)			
Room and Board (facility daily rate)			*CalOptima (Claims)*
Professional services	X		
Ancillary services	X		
Maintenance and Transportation (CCS specific)**			**CalOptima**
Mammography and Screening	X		

Medical/Surgical Supplies and Dressings[1]	**X**					

	Physician		**Hospital Budget**		**Other**
Medical Therapy Program (MTP) (CCS specific)					***OC HCA / State***

Medication

Inpatient					
--Acute Medical			**X**		
--Acute Psychiatric					***OC HCA***
--Long Term Care Facility	**X**				
Outpatient Medication dispensed by a Pharmacy	**X**				

Hepatitis C Medication*					***DHCS***
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered injectables and injectable chemotherapeutic medication	**X**				
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***				
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***

Mental Health

Specialty Mental Health Professional Services - Inpatient, Outpatient, & Long Term Care					***OC HCA / State***
Mild to moderate impairments outside the PCP's scope of service **includes ABA Services**	**X**				
Alcohol Misuse Screening, and Counseling (AMSC) by PCP	**X**				
Acute Inpatient - medical consults, diagnostics and treatment, history and physicals	**X**				
Long Term Care Psychiatric (Special Treatment Programs) - medical consults, diagnostics and treatment, history and physicals, and ancillary services excluded from facility daily rate	**X**				
Psychiatric evaluations that are a component of a surgical or medical treatment (example - gastric bypass surgery)	**X**				
Medical Services related to outpatient Electro-Convulsive Treatment (ECT) – examples- H&P, labs, EKG, radiology services, anesthesiology professional fees.	**X**				
Facility fees and supplies related to outpatient Electro-Convulsive Treatment (ECT)			**X**		

Neuropsych Testing (Medical/organic conditions)	**X**				

	Physician	Hospital Budget	Other
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	X		
Facility Technical Component (hospital & free-standing centers)		X	
Nutritional Dietetic Counseling / Medical Nutrition Therapy	X		
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)	X		
Enteral Nutrition	X		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	X		
Nutrition Products	X		
Obstetrical Care			
Outpatient diagnostic services	X		
Inpatient professional component	X		
Inpatient facility component		X	
Emergent diagnostic (OB Unit)		X	
Ultrasound	X		
Perinatal care	X		
Perinatal Support Services	X		
Fetal Monitoring			
-- Professional component	X		
-- Facility component		X	
Occupational Therapy	*- See Rehabilitation -*		
Orthotics	X		
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	X		
Facility component		X	

	Physician	Hospital Budget	Other
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		

Physician Services

Inpatient	**X**		
Outpatient (including Revenue Code 510)	**X**		

Podiatry Services	**X**		

Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
-- Vaccine			***VFC (Vaccines for Children Program)***
-- Administration fee	**X**		
Immunizations (19 years and over)			
-- Vaccine (inclusive of Medi-Cal administration fee)	**X**		
Adult Periodic Health Exams	**X**		

Prosthetic Devices

Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		

Radiation Therapy

Professional component – (codes 77000-77799: modifier 26)	**X**		
Facility component		**X**	

Radiology Services	***- See Diagnostic Services -***		

	Physician	Hospital Budget	Other
Rehabilitation - Physical, Occupational, & Speech Therapy			
Inpatient professional component	X		
Inpatient facility component		X	
Outpatient professional component[1]	X		
Outpatient facility component[1]	X		
Long Term Care Facility	X		
Skilled Nursing Facility			
Custodial – Long Term Care	*- See Long Term Care Services -*		
Short stay	*- See Hospitalization -*		
Speech Therapy	*- See Rehabilitation -*		
Transgender Services			
Professional component	X		
Facility component		X	
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	X		
Facility component		X	
Transplants - Including Procurement			
Organ Transplants Evaluations	X		
Organ Transplants	X		
All Other Transplants (e.g. bone, cornea, skin)			
--Professional Component	X		
--Facility Component		X	
Transportation (includes ambulance)			
Emergency and non-emergency medical transportation (NEMT)		X	
Non Medical transportation (NMT)		X	
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			*OC HCA Responsibility*
Non-DOT TB Treatment provided by OC HCA	X		
Non-DOT TB Treatment provided by non-OC HCA Provider	X		

	Physician		Hospital Budget		Other
Vision Care					
Routine adult and child eye refraction examination	X				
Contact lenses[2]	X				
Lenses and frames[2]	X				
Argon laser trabeculoplasty	X				
Intraocular lens - surgically implanted			X		
Ophthalmological services	X				
Prosthetic eye	X				

***For reimbursement of Hepatitis C Medications HMO shall submit data through CalOptima to DHCS.**
**** CCS specific services are paid per Section 9.**

[1] ***Services are the responsibility of MTP if provided under the MTP program.***
[2] ***These services are subject to Medi-Cal coverage guidelines and limitations.***

ATTACHMENT B

DISCLOSURE FORM

Kaiser Foundation Health Plan, Inc
Name of Provider

The undersigned hereby certifies that the following information regarding Kaiser Foundation Health Plan, Inc. (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
Gregory A. Adams, Ramón F. Baez, David J. Barger, Regina M. Benjamin, Jeffrey E. Epstein, Leslie S. Heisz, David F. Hoffmeister, Judith A. Johansen, Margaret E. Porfido, Matthew T. Ryan, Richard P. Shannon, Cynthia A. Telles, A. Eugene Washington, Kathryn L. Lancaster, Mark S. Zemelman

Co-Owner(s):
N/A

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
N/A

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
N/A

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
California nonprofit public benefit corporation

Dated: Feb 9, 2021

Signature: George Di Salvo
George Di Salvo (Feb 9, 2021 17:18 PST)

Name: George Disalvo
(Please type or print)

Title: Chief Financial Officer, Southern California
(Please type or print)

ATTACHMENT C

NOT APPLICABLE TO THIS CONTRACT

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, Kaiser Foundation Health Plan, Inc, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

George Di Salvo
George Di Salvo (Feb 9, 2021 17:18 PST)

Signed

Feb 9, 2021

Date

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ATTACHMENT E
Capitation Rates

Effective July 1, 2017

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

ADULT & FAMILY AID CATEGORY / OPTIONAL TARGETED LOW-INCOME CHILD (UNDER 19)	Age/Gender Group	Hospital	Professional	Rx	Total
01 02 03 04 06 07 08 30 32 33 34 35 37 38 39 40 42 43 45 46 47 49 54 59 72 82 83 0A 3A 3C 3E 3F 3G 3H 3L 3M 3N 3P 3R 3U 3W 4A 4F 4G 4H 4K 4L 4M 4N 4S 4T 4W 5K 7A 7J 7S 7W 7X 8P 8R 81 86 87 E2 E5 K1 M3 M7 P5 P7 P9	0 - 18	[redacted]	[redacted]	[redacted]	[redacted]
HEALTHY FAMILIES AID CATEGORY (ADULT & FAMILY AID CATEGORY / OPTIONAL TARGETED LOW-INCOME CHILD (UNDER 19))	Age/Gender Group	Hospital	Professional	Rx	Total
5C 5D H1 H2 H3 H4 H5 E6 E7 M5 T1 T2 T3 T4 T5	All Ages	[redacted]	[redacted]	[redacted]	[redacted]
ADULT & FAMILY AID CATEGORY / OPTIONAL TARGETED LOW-INCOME CHILD (19 & OLDER)	Age/Gender Group	Hospital	Professional	Rx	Total
01 02 03 04 06 07 08 30 32 33 34 35 37 38 39 40 42 43 45 46 47 49 54 59 72 82 83 0A 3A 3C 3E 3F 3G 3H 3L 3M 3N 3P 3R 3U 3W 4A 4F 4G 4H 4K 4L 4M 4N 4S 4T 4W 5K 7A 7J 7S 7W 7X 8P 8R 81 86 87 E2 E5 K1 M3 M7 P5 P7 P9	19 and Over	[redacted]	[redacted]	[redacted]	[redacted]
AGED AID CATEGORY	Age/Gender Group	Hospital	Professional	Rx	Total
10 14 16 17 1E 1H	All Ages	[redacted]	[redacted]	[redacted]	[redacted]

DISABLED AID CATEGORY	Age/Gender Group	Hospital	Professional	Rx	Total
20 24 26 27 36 60 64 66 67 2E 2H 6A 6C 6E 6G 6H 6J 6N 6P 6R 6V 6W 6X 6Y	All Ages	[redacted]	[redacted]	[redacted]	[redacted]

BCCTP AID CATEGORY	Age/Gender Group	Hospital	Professional	Rx	Total
0M 0N 0P 0R 0T 0U 0W	All Ages	[redacted]	[redacted]	[redacted]	[redacted]

Hepatitis C Weekly Payment (Jul 1 2017-Dec 31 2017)

Aid Category	Age/Gender Group	Hospital	Professional	Rx	Total
All Aid Category - Non-340B	All Ages	[redacted]			
All Aid Category - 340B	All Ages				

Hepatitis C Weekly Payment (Jan 1 2018-Jun 30 2019)

Aid Category	Age/Gender Group	Hospital	Professional	Rx	Total
All Aid Category - Non-340B	All Ages	[redacted]			
All Aid Category - 340B	All Ages				

BHT Supplemental Payment

Aid Category	Age/Gender Group	Hospital	Professional	Rx	Total
All Aid Category	0-6	[redacted]			
All Aid Category	7-20				

Payment for Whole Child Model Members:

CalOptima shall pay to HMO a monthly capitation payment of [redacted] (amounting to [redacted] PMPM with [redacted] administrative withhold) of the capitation payment received by CalOptima from DHCS for each CCS-Eligible Member assigned to HMO for Administrative Services provided to CCS-Eligible Members.

ATTACHMENT E-1
Capitation Rates for Adult Expansion Members

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to HMO.

Effective July 1, 2017

MSI & MCX AID CATEGORY (Adult Expansion)	Age/Gender Group	Hospital	Professional	Rx	Total
L1 7U M1	All Ages	[redacted]	[redacted]	[redacted]	[redacted]

ATTACHMENT E-2
DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program described in California State Plan Amendment 18-0033.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to HMOs for certain procedures as defined in the All Plan Letter (APL) 18-010 and DHCS guidance ("Prop 56 Payments").

CalOptima agrees to make certain Prop 56 Payments to HMO which HMO agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in the Attachment) effective July 1, 2017 and CalOptima agrees to pay HMO an administrative fee to administer such Prop 56 Payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

   a. "Eligible Contracted Provider" shall mean a Medical Group or Provider who is contracted with HMO to provide Medi-Cal services to CalOptima members assigned to HMO. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   b. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   c. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. HMO shall administer the Prop 56 Payments in accordance with applicable state and federal requirements. HMO shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by HMO to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 Payments funding for payments required to be paid by HMO for Qualifying Services furnished by Eligible Contracted Providers. Funding for the Prop 56 Payments shall be contingent upon HMO submitting monthly completed claim and encounter reports to CalOptima in a defined format. Once Eligible Contracted Provider payment is confirmed, based on the monthly reports required under Section 5., below, CalOptima shall reimburse HMO for payments made during the prior reporting period.

4. HMO shall not provide supplemental Prop 56 payments under this Attachment to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Prop 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by HMO.

5. HMO shall forward to CalOptima, a monthly report in a CalOptima defined format, detailing the payments made to Eligible Contracted Providers.

6. CalOptima will pay HMO a two percent (2%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 Payments have been made by HMO to Eligible Contracted Providers based upon the reports required under Section 5 above. Once Provider payment is confirmed, a 2% administrative component based on confirmed Prop 56 Payments shall be remitted to HMO.

7. CalOptima's obligation to pay HMO any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 Payments. In no event shall CalOptima be obligated to pay Administrative Fees to HMO if CalOptima has not received funding for administration of the Prop 56 Payments from DHCS.

8. HMO acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Payments identifies invalid payments, HMO shall return such Prop 56 Payments to CalOptima immediately upon notice from CalOptima.

9. HMO agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Payments. HMO agrees to comply with all other applicable Federal and State laws and guidance and CalOptima Policies related to the Prop 56 Payments.

10. As long as the State of California extends the Prop 56 Payments to CalOptima, CalOptima will continue to make Prop 56 Payments to HMO, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018

HMO shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to HMO prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019

HMO shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to HMO. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by HMO no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	$77.00
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	$80.00
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	$77.00
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	$83.00
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1-year-old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-19 years old)	$27.00

ATTACHMENT F-1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Kaiser Foundation Health Plan, Inc.	George DiSalvo
Name of Contractor	Printed Name of Person Signing for Contractor
KFHP/CalOptima	George Di Salvo George Di Salvo (Feb 9, 2021 17:18 PST)
Contract / Grant Number	Signature of Person Signing for Contractor
Feb 9, 2021	Chief Financial Officer, Southern California
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: N/A contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: N/A bid/offer/application initial award post-award	3. Report Type: N/A initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Tier Prime N/A Subawardee, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: N/A Congressional District, If known:
6. Federal Department/Agency: N/A	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known: N/A	9. Award Amount, if known: N/A
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): N/A (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (check all that apply): N/A a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
Form of Payment (check all that apply): a. cash N/A b. in-kind, specify: Nature Value	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

N/A

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No N/A

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: N/A Print Name: N/A Title: N/A Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11199982AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Amendment, Rate Amendment
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Effective date of Agreement:	October 1, 2019
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	Restate the Division of Financial Responsibilities as well as provide the requirements for the distribution of Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) Funding.
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 11, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11199982AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment, etc) _Contract ID: **C11199982AA**

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AMENDMENT I TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT I TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of October 1, 2019 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO wish to enter into this amendment to restate the Division of Financial Responsibilities as well as provide the requirements for the distribution of Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) Funding.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility" shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I.

2. Attachment E-3, "Distribution of GEMT QAF Funding", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
George Di Salvo George Di Salvo (Feb 9, 2021 12:01 PST)	Ladan Khamseh
SIGNATURE	SIGNATURE
George Di Salvo	Ladan Khamseh
PRINT NAME	PRINT NAME
CFO - SCAL	Chief Operating Officer
TITLE	TITLE
Feb 9, 2021	2/9/2021
DATE	DATE

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Contract for Health Care Services
Amendment I

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the HMO components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the HMO Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. Kaiser Foundation Health Plan, Inc. is the responsible party for Covered Services designated under "Physician" and "Hospital Budget" columns. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	*- See Transportation -*		
Amniocentesis	X		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc....)			
Professional component	X		
Facility component		X	
Birth Control	*- See Family Planning -*		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
Community-Based Adult Services (CBAS)	X		
CHDP	*- See Pediatric Preventive Services -*		
Chemotherapy			
Professional Component	X		
Outpatient Facility Component		X	
Medication (see Medication)			
Chiropractic Services	X		

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	Physician		Hospital		Other
Cosmetic Surgery (Medically necessary)					
Professional component	X				
Facility component (licensed surgical center or acute facility only)			X		
Dental Services					
General dental services - Including teeth					*Denti-Cal*
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	X				
Facility component			X		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	X				
Professional component (Provided by Dentist)					*Denti-Cal*
Facility component			X		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	X				
Facility component			X		
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related supplies & drugs required for the service- example dyes injected for imaging)					
Professional and Facility Components	X				
Diagnostic Services (Inpatient), Including Radiology					
Professional Component	X				
Facility Component			X		
Dialysis					
Professional component	X				
Facility component			X		
DOT (Directly Observed Therapy) TB Treatment					*OCHCA*
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			X		
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings)	X				
Custom Wheelchair Assessment (excluding those conducted through Medical Therapy Program [MTP])	X				
Custom Wheelchair Assessment through MTP					*OC HCA/State*
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			X		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	X				
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions, and the technical component of diagnostic testing.			X		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					*OC HCA / State*
EPSDT Services					
Acupuncture	X				
Autism Screening	X				
Audiology	X				
Chiropractic	X				
Cochlear Implant	X				
Dental Services					*State*
EPSDT Case Management	X				
Hearing Aid Batteries	X				
In-Home Private Duty Nursing (PDN)	X				
Medical Nutrition Services	X				
Occupational Therapy[1]	X				
Orthodontic Services					*Denti-Cal*
Pediatric Day Health Care Services (through EPSDT or through CCS)					*State*
Speech Therapy	X				
Mental Health - Specialty Outpatient					*OC HCA / State*
Family Planning (including birth control)					
Professional component	X				
Facility component			X		
IUDs	X				
Contraceptive items/supplies and drugs provided by the family planning clinic	X				
Non-Injectable drugs	*- See Medication -*				
Implants/Injections	*- See Medication -*				
Contraceptive items/ supplies	X				
Genetic Disease Screening					
Prenatal Triple Marker Screening					*DHCS Genetic Disease Branch*
Follow-up services for positive prenatal screening					*DHCS Genetic Disease Branch*
Newborn screening panel			X		
Other Genetic Testing/Counseling	X				
Hearing Aids	X				
Hearing Screening	X				

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	Physician	Hospital	Other
Home Health Care			
Care for medical conditions		X	
Care for psychiatric conditions			*OC HCA / State*
Injectable medications	*-See Medication -*		
Home infusion	*-See Medication -*		
Home Health and Home Infusion Pumps & Supplies		X	
Hospice Services (ALL levels of services at any facility/location/setting)		X	
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		X	
Psychiatric			*OC HCA / State*
Hyperbaric Oxygen Therapy		X	
Immunizations	*- See Preventive Services -*		
Incontinence Creams and Washes[2]	X		
Injectables	*- See Medications -*		
Laboratory Services			
Inpatient - Medical (technical component)		X	
Inpatient – Psychiatric			*OC HCA / State*
Outpatient (Including surgical pathology services)	X		
Emergency	*- See Emergency Services -*		
Long-Term Care Services, including Custodial (Sub-acute, SNF, ICF, ICF/DD, ICF/DD-N, ICF/DD-H)			
Room and Board (facility daily rate)			*CalOptima (Claims)*
Professional services	X		
Ancillary services	X		
Mammography and Screening	X		
Medical/Surgical Supplies and Dressings[1]	X		
Medical Therapy Program (MTP) (CCS specific)			*OC HCA / State*
Medication			
Inpatient			
Acute Medical		X	
Acute Psychiatric			*OC HCA*
Long Term Care Facility	X		
Outpatient Medication dispensed by a Pharmacy	X		
Hepatitis C Medication*			*DHCS*
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered injectables and injectable chemotherapeutic medication	X		
Enteral and Parenteral Nutrients, Pumps and Supplies	*- See Nutritional Products -*		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			*DHCS*

	Physician		Hospital		Other
Mental Health					
Specialty Mental Health Professional Services - Inpatient, Outpatient, & Long-Term Care					*OC HCA / State*
Mild to moderate impairments outside the PCP's scope of service includes ABA Services	X				
Alcohol Misuse Screening, and Counseling (AMSC) by PCP	X				
Acute Inpatient - medical consults, diagnostics and treatment, history and physicals	X				
Long Term Care Psychiatric (Special Treatment Programs) - medical consults, diagnostics and treatment, history and physicals, and ancillary services excluded from facility daily rate	X				
Psychiatric evaluations that are a component of a surgical or medical treatment (example - gastric bypass surgery)	X				
Medical Services related to outpatient Electro-Convulsive Treatment (ECT) – examples- H&P, labs, EKG, radiology services, anesthesiology professional fees.	X				
Facility fees and supplies related to outpatient Electro-Convulsive Treatment (ECT)			X		
Neuropsych Testing (Medical/organic conditions)	X				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	X				
Facility Technical Component (hospital & free-standing centers)			X		
Nutritional Dietetic Counseling / Medical Nutrition Therapy	X				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)	X				
Enteral Nutrition	X				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	X				
Other Nutrition Products	X				
Obstetrical Care					
Outpatient diagnostic services	X				
Inpatient professional component	X				
Inpatient facility component			X		
Emergent diagnostic (OB Unit)			X		
Ultrasound	X				
Perinatal care	X				
Perinatal Support Services	X				
Fetal Monitoring					
Professional component	X				
Facility component			X		
Occupational Therapy	*- See Rehabilitation -*				
Orthotics	X				
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*				

	Physician		Hospital		Other
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	X				
Facility component			X		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	*- See Medication -*				
Physical Therapy	*- See Rehabilitation -*				
Physician Services					
Inpatient	X				
Outpatient (including Revenue Code 510)	X				
Podiatry Services	X				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	X				
Immunizations (Ages 0-18 years)					
Vaccine					*VFC (Vaccines for Children Program)*
Administration fee	X				
Immunizations (19 years and over)					
Vaccine (inclusive of Medi-Cal administration fee)	X				
Adult Periodic Health Exams	X				
Prosthetic Devices					
Surgical implantation	X				
Surgically implanted device/prosthetic			X		
Non-implanted device/prosthetic	X				
Radiation Therapy					
Professional component – (codes 77000-77799: modifier 26)	X				
Facility component			X		
Radiology Services	*- See Diagnostic Services -*				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	X				
Inpatient facility component			X		
Outpatient professional component[1]	X				
Outpatient facility component[1]	X				
Long Term Care Facility	X				
Skilled Nursing Facility					
Custodial – Long Term Care	*- See Long Term Care Services -*				
Short stay	*- See Hospitalization -*				
Speech Therapy	*- See Rehabilitation -*				
Transgender Services					
Professional component	X				
Facility component			X		
Termination of Pregnancy					
Professional component (including Mifepristone/RU-486)	X				
Facility component			X		

	Physician		Hospital		Other
Transplants - Including Procurement					
Organ Transplants Evaluations	X				
Organ Transplants	X				
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	X				
Facility Component			X		
Transportation (includes ambulance)					
Emergency and non-emergency medical transportation (NEMT)			X		
Non-Medical transportation (NMT)			X		
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					*OC HCA Responsibility*
Non-DOT TB Treatment provided by OC HCA	X				
Non-DOT TB Treatment provided by non-OC HCA Provider	X				
Vision Care					
Routine adult and child eye refraction examination	X				
Contact lenses[2]	X				
Lenses and frames[2]	X				
Argon laser trabeculoplasty	X				
Intraocular lens - surgically implanted			X		
Ophthalmological services	X				
Prosthetic eye	X				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim.	X				
Facility component including all Special Care Center services billable on a facility claim.			X		
Maintenance and Transportation**					*CalOptima (Claims)*
Medical Therapy Program					*OC HCA / State*
***For reimbursement of Hepatitis C Medications HMO shall submit data through CalOptima to DHCS. ** CCS specific services are paid per Article 9.*					
[1] ***Services are the responsibility of MTP if provided under the MTP program.*** [2] ***These services are subject to Medi-Cal coverage guidelines and limitations.***					

ATTACHMENT E-3
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and HMO, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. HMO must reimburse Eligible Non-Contracted Providers a differential totaling up to [redacted] that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to HMO, and HMO agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay HMO an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

   a. "Eligible Non-Contracted Provider" shall mean a Provider who is not contracted with HMO to provide GEMT services or a Provider who is contracted with HMO for transportation services, but not contracted with HMO to provide GEMT services to CalOptima Medi-Cal members.

   b. "Qualifying Services" shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. HMO shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to [redacted] for Qualifying Services furnished by Eligible Non-Contracted Providers. HMO is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the HMO within one year after the date of service.

3. HMO shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. HMO is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a [redacted] administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to HMO based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. HMO shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to HMO by means of a Notice to this Contract.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11200503AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Amendment
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Effective date of Amendment:	January 1, 2020
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	Amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Health Homes Program
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 11, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11200503AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment, etc) _Contract ID: **C11200503AA**

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AMENDMENT II TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT II TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, Kaiser Foundation Health Plan, Inc. ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Health Homes Program.

NOW, THEREFORE, the parties agree as follows:

1. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

"1.103 Community-Based Care Management Entity (CB-CME) means HMO when providing Health Homes Program (HHP) services to HHP Members pursuant to this Contract.

1.104 Health Homes Program or "HHP" means all of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for provision of HHP services that provide supplemental services to HHP eligible and enrolled Members by coordinating and integrating the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed for chronic conditions.

1.105 HHP Member who is HHP enrolled, and continuously participating in the HHP and assigned to the HMO.

1.106 HHP Multi-Disciplinary Care Team means a team of staff employed or contracted by the HMO, as a CB-CME, that provides HHP services to HHP Members."

2. Section 6.22 shall be added as follows:

"6.22 HEALTH HOMES PROGRAM ---

6.22.1 HMO shall begin participating in CalOptima Health Homes Program, as follows: (i) Effective January 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible chronic physical conditions and substance use disorders; and (ii) Effective July 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible serious mental illness.

6.22.2 HMO shall be responsible for providing and coordinating HHP services as one of the designated Community-Based Care Management Entities (CB-CMEs). HMO, as a CB-CME, shall ensure its systems and infrastructure are in place to provide HHP services to HHP Members. HMO, as a CB-CME, shall satisfy the CB-CME qualification standards as defined by DHCS and

CalOptima Policy, and CB-CME certification requirements as described in DHCS HHP Program Guide.

6.22.3 HMO shall comply with all State and federal requirements related to HHP and HHP requirements determined by DHCS, including the All Plan Letter related to Health Homes Program requirements and the HHP Program Guide. HMO, as a CB-CME, shall implement CalOptima Health Homes Program in accordance with this Contract and CalOptima Policies. HMO shall ensure that HMO staff who will be delivering HHP services complete training required by CalOptima and DHCS prior to participating in the administrative of the HHP.

6.22.4 HMO, as a CB-CME, shall be responsible for coordinating care with HHP Members, Providers, and other agencies as appropriate. HMO shall provide the following six (6) core HHP service categories for HHP Members: (i) Comprehensive care management; (ii) Care coordination; (iii) Health promotion; (iv) Comprehensive transitional care; (v) Individual and family support services; and (vi) Referral to community and social supports.

6.22.5 HMO shall maintain an aggregate minimum care coordinator ratio as defined by DHCS. HMO shall ensure the establishment of HHP Multi-Disciplinary Care Teams to provide HHP services, as set forth in CalOptima Policy GG.1331.

6.22.6 HMO shall ensure availability of Providers with experience working with people who are chronically homeless, pursuant to Welfare & Institutions Code section 14127.31(d)(1)(B).

6.22.7 HMO shall establish, as necessary, contractual relationships with organizations to provide HHP services (including but not limited to office visit accompaniment, housing navigator, individual housing transition services, and individual housing and tenancy sustaining services), and contractual or non-contractual relationships to provide linkages to community and social support services. Regardless of the subcontracting arrangement, HMO shall retain overall responsibility for all CB-CME duties and responsibilities set forth in this Contract and CalOptima Policies.

6.22.8 HMO shall conduct outreach and engagement activities for HHP-eligible Members who are not enrolled in HHP. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent to HHP participation may be oral or in writing and shall be documented by the HMO's Customer Service staff or HHP Multidisciplinary Care Team staff prior to the Member's participation in HHP. CalOptima and HMO will coordinate to ensure that Members who meet exclusionary criteria are excluded or disenrolled from the HHP pursuant to the HHP Program Guide and CalOptima Policy GG.1350.

6.22. 9 HMO, as a CB-CME, shall complete a health needs assessment (HNA) and develop a health action plan (HAP) for each HHP Member. HMO shall ensure case conferences are conducted by the HHP Multidisciplinary Care Team and the HHP Member's HNA and HAP are updated as necessary.

6.22.10 HMO may use HHP funding to make payments to HHP Members' network Providers who are not included formally on the HMO's HHP Multi-Disciplinary Care Team, but who are responsible for coordinating with the HMO's HHP care coordinator to conduct case conferences and to provide input to the health action plan (HAP).

6.22.11 In addition to other provisions of this Contract, HMO shall comply with CalOptima Policies GG.1331, GG.1350 and FF.4001 related to CB-CME duties and responsibilities, including engagement activities, the DHCS HHP Program Guide, and CB-CME requirements set forth in Welfare & Institutions Code, section 14127.3(d)(1).

6.22.12 HMO's Agent's Qualifications. HMO shall verify the qualifications of all agents (including HMO staff) providing services under this Contract consistent with the services to be provided under the Health Homes Program. In addition, for agents that enter into Members' homes or have face-to-face contact with Members, HMO shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. HMO shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

6.22.13 HHP Data Sharing. CalOptima and HMO agree to exchange available information and data as required by DHCS for the HHP, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of HHP Members. CalOptima and HMO shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements, and other federal and California state laws and regulations, including applying the minimum necessary standard, when applicable. Further, HMO shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an HHP Member's valid authorization for release of health information and a legal exception does not apply, HMO may not release such information without the HHP Member's valid authorization.

6.22.14 HHP Data Reporting. HMO shall submit to CalOptima complete, accurate, reasonable and timely data reports in the manner and form acceptable to CalOptima in order for CalOptima to meet its data reporting requirements to DHCS for the HHP."

3. Attachment E-4, "Funding for Health Homes Program", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Kaiser Foundation Health Plan, Inc. have executed this Amendment:

FOR HMO:

George Di Salvo
George Di Salvo (Feb 9, 2021 12:32 PST)
SIGNATURE

George Di Salvo
PRINT NAME

CFO - SCAL
TITLE

Feb 9, 2021
DATE

FOR CALOPTIMA:

SIGNATURE

Ladan Khamseh
PRINT NAME

Chief Operating Officer
TITLE

2/9/2021
DATE

Attachment E-4

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to HMO for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

   1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
   - Member is enrolled in the HHP;
   - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the HMO, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the HMO;
   - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
   - If applicable, the HMO paid the provider for the HHP core services; and
   - The HMO authorized such HHP core services.

   [redacted] PMPM (January – June 2020)
   [redacted] PMPM (July – December 2020)

2. Engagement Activities Supplemental Capitation Payment

   2.1 Subject to Section 2.2 of this Attachment E-4, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
   - The HMO conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
   - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
   - If applicable, the HMO authorized and paid the provider for such engagement

   [redacted] PMPM (January – June 2020)
   [redacted] PMPM (July – December 2020)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. HMO shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15^{th}) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11200669AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Amendment, Rate Amendment
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Effective date of Amendment:	January 1, 2020
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	Amend the Contract for the allocation and distribution of Intergovernmental Transfer (IGT) 6 and 7 Funds for Whole-Child Model (WCM) Startup Expenses incurred by HMO. IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 1-7 funds are designated for enhanced/additional benefits for Medi-Cal beneficiaries.
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 11, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11200669AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment, etc). Contract ID: **C11200669AA**

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AMENDMENT III TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT III TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract for the allocation and distribution of Intergovernmental Transfer (IGT) 6 and 7 Funds for Whole-Child Model (WCM) Startup Expenses incurred by HMO. IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 1–7 funds are designated for enhanced/additional benefits for Medi-Cal beneficiaries.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-5, "Whole-Child Model (WCM) Start-up Expenses Reimbursement", shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
George Di Salvo George Di Salvo (Feb 9, 2021 12:33 PST)	Ladan Khamseh
SIGNATURE	SIGNATURE
George Di Salvo	Ladan Khamseh
PRINT NAME	PRINT NAME
CFO - SCAL	Chief Operating Officer
TITLE	TITLE
Feb 9, 2021	2/9/2021
DATE	DATE

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Attachment E-5

Whole-Child Model (WCM) Program Start-up Expense Reimbursement

This attachment sets forth the program of additional compensation for Whole Child Model (WCM) start-up expenses, as authorized by the CalOptima Board of Directors at its December 5, 2019, meeting.

A. Reimbursement Available. There are two parts of the expense related reimbursement payments available to HMO.

1. Flat Rate: HMO shall receive a one-time payment amount of [redacted] AND,

2. Variable Rate: If expenses for the implementation, as described in this Attachment, exceed the [redacted] flat rate, an additional amount of up to [redacted] per member per month, shall be reimbursed to HMO. This maximum funding amount has been calculated based on the average number of CCS Members assigned to HMO from July through September 2019.

B. Reimbursable Expenses. Reimbursement under the variable rate reimbursement category is limited to those expenses that were incurred prior to July 1, 2019. There are three broad categories of reimbursable expenses for the variable rate reimbursements, as follows:

1. Personnel Expenses—These expenses relate to the reassignment, recruitment and training of administrative personnel for implementation of the WCM, including both the cost of diverting existing staff (such as reassigning claims payment staff to prepare WCM-specific claims processing policies, procedures, and routines), the cost of recruiting new staff to carry out WCM-specific tasks (such as utilization management, case management, and claims processing for WCM services), and the cost of training (such as bringing in outside trainers, preparing training materials, and overseeing on-line training activities for staff on WCM-specific matters).

2. Systems and Infrastructure—These expenses include those expenses involved in establishing a DHCS-compliant WCM provider network, such as contracting and credentialing additional CCS-approved physicians and facilities; necessary modifications to electronic data systems; additional office equipment for new WCM-specific staff; acquisition of new software or new modules for existing software made necessary by operation of the WCM; and development of program reporting capabilities to meet the requirements of the CalOptima WCM program.

3. Other Expenses—This category includes other expenses incurred in preparation for the implementation of the WCM, such as member notifications, educational materials for members, providers, and/or HMO administrative staff, and other items that are dedicated to WCM implementation that are not covered by reimbursable expense categories 1. and 2.

C. Reimbursement

1. The flat fee reimbursement shall be paid by CalOptima on or before March 1, 2020.

2. The variable rate reimbursement shall be paid by CalOptima within thirty (30) days of confirmation that the following have been submitted, are consistent between the attestation and invoice (see below), are consistent with the costs that are reimbursable, and are accepted as complete:

2.1. An attestation, in the format designated by CalOptima, indicating the general nature and amount of expenditures incurred prior to July 1, 2019, for each of the three broad reimbursable expense categories, signed by an authorized signer for HMO.

2.2. A detailed invoice specifically describing the costs incurred, prior to July 1, 2019, in preparation for implementation of the WCM, as follows:

2.2.1 Personnel Costs—For HMO personnel costs in each category identify the job title, hours, and total compensation incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.2. Contractual Services—For services obtained from other than HMO personnel, indicate each contracted party, a general identification of the services provided, and the costs incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.3 Goods/Materials—For goods and materials, indicate the type of goods procured, from whom the goods were acquired, for what purpose the goods were used, and the cost of each type of goods obtained, and how the expenses relate to preparation for implementation of the WCM.

D. Audit.

1. CalOptima is not requiring that supporting documentation, such as contracts and invoices from providers of goods and services, or employment records for personnel undertaking preparations for implementation of the WCM, be provided with the attestation and invoices. However, HMO shall maintain such records in a reasonably accessible manner for inspection by CalOptima or its designated auditor.

2. CalOptima, or its designated auditor, shall audit HMO's records during the annual financial audit to verify that the expenses were incurred as reported in the invoicing

and attestation. Reimbursement of both flat and variable rate start-up expenses are subject to recoupment if substantiating documentation is not made available. Substantiating documentation may include, but not be limited to, salary and payroll information as described in Section 1.1.2; general ledger entries identifying the start-up expenses; contracts and invoices from third party providers of goods and services, and copies of cancelled checks to support payment of expenses.

3. Any variable rate reimbursement amounts that are found to not have been incurred, or not to be supported by sufficient documentation, shall be disallowed retroactively. Such disallowed amounts will constitute an overpayment and will be returned to CalOptima or recovered through offset, as provided elsewhere in this Contract.

E. Disputes. In the event that CalOptima disallows any expense incurred and properly attested and invoiced, HMO shall have the right to pursue those remedies identified in this Contract and CalOptima Provider Dispute and Appeals policies.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11200726AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Amendment, Rate Amendment
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Effective date of Amendment:	April 1, 2020
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	Amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the Cal Optima Board of Directors for immediate aid due to the coronavirus known as COVID-19.
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 11, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11200726AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment, etc) _Contract ID: **C11200726AA**

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AMENDMENT IV TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IV TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the coronavirus known as COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-6, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
George Di Salvo George Di Salvo (Feb 9, 2021 12:33 PST)	
SIGNATURE	SIGNATURE
George Di Salvo	Ladan Khamseh
PRINT NAME	PRINT NAME
CFO - SCAL	Chief Operating Officer
TITLE	TITLE
Feb 9, 2021	2/9/2021
DATE	DATE

ATTACHMENT E-6

MEDI-CAL RATE ENHANCEMENT

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). Pursuant to the action taken by CalOptima Board of Directors on April 2, 2020, in anticipation of a fluctuation in utilization by Medi-Cal members and the need for flexible services due to COVID-19, CalOptima amends the current Medi-Cal capitation base rate levels set forth in Attachment E to increase them by [redacted] for the period commencing April, 1 2020 and continuing through, and including, June 30, 2020.

Contract Summary Transmittal Form

Provider(s):	**Kaiser Foundation Health Plan, Inc.** 393 E Walnut Street Pasadena, CA 91188 Ph: 626-405-5086
Provider Contact Information:	Javier Sanchez Executive Director, Medi-Cal Contract Management Work: 626-405-3281 Cell: 626-808-6194 Javier.F.Sanchez@KP.org Emily Daniels, MPH Sr Managerial Consultant, Medi-Cal Contract Management Cell: 626-298-4988 Emily.M.Daniels@kp.org
Contract ID	C11200795AA
TIN	951750445
Contract Group Type	HMO
Contract Service Category	Health Network
Type of Provider:	HMO
Specialty	HMO
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	Medi-Cal
Type of Document:	Amendment
FDR Packet Notification: (for delegated or non-healthcare provider)	Yes
Credentialing Completed by QI: (for new contracts only) Date:	N/A N/A
Payment Type	Capitated
Payment Method	N/A
Vendor PO Number	N/A
Effective date of Initial Agreement:	July 1, 2019
Effective date of Amendment:	July 1, 2020
Termination date of Agreement:	Annual Renewal Upon Board Approval
Contract Justification:	Amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure, revise the capitation rates, remove Medical pharmacy services effective with the transition of Pharmacy to DHCS Medi-Cal Rx and address other changes to the terms as specified herein.
Financial Justification:	N/A
Negotiator:	Arely Livi
Date:	March 11, 2021
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson – [Contract ID: **C11200795AA**; See Contract PDF or Contract Scanned Image under the Signature Info Tab]	

*Expedite as directed by Contract Manager when Contract Summary is e-mailed to Coordinator (for contracts/amendments that need new rate agreement set up, for a rate change amendment, etc) _Contract ID: **C11200795AA**

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AMENDMENT V TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT V TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2020, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure, revise the capitation rates, remove Medi-Cal pharmacy services effective with the transition of Pharmacy to DHCS Medi-Cal Rx and address other changes to the terms as specified herein.

NOW, THEREFORE, the parties agree as follows:

1. Recital C as set forth in the Contract is deleted in its entirety and replaced with the following:

"HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein. Subject to transition requirements, effective no earlier than April 1, 2021, DHCS will transition all administrative services and financial risk related to Medi-Cal pharmacy benefits from CalOptima to DHCS Medi-Cal Rx. If DHCS delays the implementation for this transition, the effective date of the removal of pharmacy responsibilities from this Contract shall be based on the actual transition date implemented by DHCS."

2. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 1.8, "Approved Drug List", shall be deleted and intentionally left blank.

3. Section 2.7.18. of the Contract shall be deleted in its entirety and replaced with the following:

"2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and HMO shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-2 and E-3, by HMO to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to HMO."

4. Section 9.15 shall be added to the Contract as follows:

"9.15 CONFIDENTIALITY OF CAPITATION RATES. CalOptima and HMO, and their respective officers, directors, employees, agents and representatives, shall keep in strictest confidence and not disclose to any other individual or entity, the Capitation Rates set forth in this

Amendment or Capitation Payments made pursuant to this Amendment for a period of three years from the effective date of this Amendment V, except disclosures may be made: (1) pursuant to the Public Records Act, California Government Code Section 6250 et seq., or as otherwise required by law or a government official or government agency with regulatory jurisdiction over CalOptima or HMO, (2) as required in legal proceedings or government administrative hearings, (3) as necessary to enforce CalOptima's or HMO's rights under this Contract, (4) as mutually agreed by CalOptima and HMO, or (5) to CalOptima's or HMO's accountants, attorneys, auditors and other professional advisors to whom disclosure is reasonably necessary to effect the purpose for which they have been consulted. Failure to maintain such confidentiality shall constitute breach of this Contract by the disclosing party."

5. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.4, "Approved Drug List", shall be deleted and intentionally left blank.

6. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.5, "Review of Off-Approved Drug Prescriptions", shall be deleted and intentionally left blank.

7. Section 13.9, "Termination for Convenience", shall be deleted in its entirety and replaced with the following:

"13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination."

8. Section 13.15, "Notice of Non-Renewal", shall be deleted in its entirety and replaced with the following:

"13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, HMO shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event HMO elects or intends not to participate in any extension period or new contract term beyond the end of the then current Contract term. HMO further acknowledges and agrees to comply with the foregoing requirements related to advance notice of non-renewal of the Contract notwithstanding the end date of the Contract term as set forth in any Contract amendment(s), including any amendment(s) which extended the Contract term for purposes of contract negotiations."

9. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS AMENDED AND RESTATED CONTRACT SHALL BE JULY 1, 2019 THROUGH JUNE 30, 2021."

10. Effective April 1, 2021, or such later date that CalOptima's Medi-Cal Pharmacy Benefits are transitioned to DHCS Medi-Cal Rx, Attachment A, "CalOptima Medi-Cal Division of Financial

Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment V.

11. Attachment E, "Capitation Rates", and Attachment E-1, "Capitation Rates for Adult Expansion Members", shall be deleted in its entirety and replaced with the attached Attachment E – Amendment V.

12. ATTACHMENT E-2 "Distribution of Proposition 56 Funding" and Addendums to this Attachment shall be deleted and replaced with the attached ATTACHMENT E-2 – AMENDMENT V, "Distribution of Proposition 56 Funding".

13. ATTACHMENT E-3 "Distribution of GEMT QAF Funding" shall be deleted and replaced with the attached ATTACHMENT E-3 – AMENDMENT V, "Distribution of GEMT QAF Funding".

14. Attachment E-4, "Funding for Health Homes Program (HHP)" is deleted in its entirety and replaced with the attached Attachment E-4 – Amendment V.

15. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:

George Di Salvo
George Di Salvo (Feb 9, 2021 12:53 PST)
SIGNATURE

George Di Salvo
PRINT NAME

CFO - SCAL
TITLE

Feb 9, 2021
DATE

FOR CALOPTIMA:

SIGNATURE

Ladan Khamseh
PRINT NAME

Chief Operating Officer
TITLE

2/9/2021
DATE

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Amendment V

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility
Effective April 1, 2021

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the HMO components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the HMO Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. Kaiser Foundation Health Plan, Inc. is the responsible party for Covered Services designated under "Physician" and "Hospital Budget" columns. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	*- See Transportation -*		
Amniocentesis	X		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc....)			
Professional component	X		
Facility component		X	
Birth Control	*- See Family Planning -*		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
Community-Based Adult Services (CBAS)	X		
CHDP	*- See Pediatric Preventive Services -*		
Chemotherapy			
Professional Component	X		
Outpatient Facility Component		X	
Medication (see Medication)			
Chiropractic Services	X		

	Physician		Hospital		Other
Cosmetic Surgery (Medically necessary)					
Professional component	X				
Facility component (licensed surgical center or acute facility only)			X		
Dental Services					
General dental services - Including teeth					*Denti-Cal*
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	X				
Facility component			X		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	X				
Professional component (Provided by Dentist)					*Denti-Cal*
Facility component			X		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	X				
Facility component			X		
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional and Facility Components	X				
Diagnostic Services (Inpatient), Including Radiology					
Professional Component	X				
Facility Component			X		
Dialysis					
Professional component	X				
Facility component			X		
Durable Medical Equipment (DME) (including insulin pumps and glucometers)					
Inpatient			X		
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings)	X				
Custom Wheelchair Assessment (excluding those conducted through Medical Therapy Program [MTP])	X				
Custom Wheelchair Assessment through MTP					*OC HCA/State*
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			X		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	X				
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions, and the technical component of diagnostic testing.			X		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					*OC HCA / State*
Enteral and Parenteral Nutrients, Pumps and Supplies	*- See Nutritional Products-*				
EPSDT Services[2]					
Acupuncture	X				
Autism Screening	X				
Audiology	X				
Chiropractic	X				
Cochlear Implant	X				
Dental Services					*State*
EPSDT Case Management	X				
Hearing Aid Batteries	X				
In-Home Private Duty Nursing (PDN)			X		
Medical Nutrition Services	X				
Occupational Therapy[1]	X				
Orthodontic Services					*Denti-Cal*
Pediatric Day Health Care Services (through EPSDT or through CCS)					*State*
Speech Therapy	X				
Mental Health - Specialty Outpatient					*OC HCA / State*
Family Planning (including birth control)					
Professional component	X				
Facility component			X		
IUDs	X				
Contraceptive items/supplies billed by non-pharmacy	X				
Condoms, diaphragms and cervical caps when billed by a Pharmacy					*DHCS PBM***
Medications	*- See Medication -*				
Genetic Disease Screening					
Prenatal Triple Marker Screening					*DHCS Genetic Disease Branch*
Follow-up services for positive prenatal screening					*DHCS Genetic Disease Branch*
Newborn screening panel			X		
Other Genetic Testing/Counseling	X				
Hearing Aids	X				
Hearing Screening	X				

	Physician		Hospital		Other
Home Health Care					
Care for medical conditions			X		
Care for psychiatric conditions					*OC HCA / State*
Injectable medications	*-See Medication -*				
Home infusion	*-See Medication -*				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			X		
Hospice Services (ALL levels of services at any facility/location/setting)			X		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			X		
Psychiatric					*OC HCA / State*
Hyperbaric Oxygen Therapy			X		
Immunizations	*- See Preventive Services -*				
Laboratory Services					
Inpatient - Medical (technical component)			X		
Inpatient – Psychiatric					*OC HCA / State*
Inpatient – Medical (professional component)	X				
Outpatient free-standing Lab or facility setting (professional and technical components)	X				
Emergency Room	*- See Emergency Services -*				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					*CalOptima (Claims)*
Professional services	X				
Ancillary services	X				
Mammography and Screening	X				
Medical/Surgical Supplies and Dressings	X				
Outpatient Medical/Surgical Supplies and Dressings					
--Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a Non-Pharmacy Provider[1]	X				
Other Disposable Medical Supplies when billed by a Pharmacy					*DHCS PBM***
Medication					
Inpatient					
Acute Medical			X		

	Physician		Hospital		Other
Acute Psychiatric					*OC HCA*
Long Term Care Facility					*DHCS PBM***
Outpatient Medication billed by a Pharmacy					*DHCS PBM***
Outpatient Medication billed by Non-Pharmacy Providers.	**X**				
Hepatitis C Medication					*DHCS PBM **
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing	**X**				
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					*OC HCA/State*
Electroconvulsive Treatment (psychiatrist)					*OC HCA/State*
Applied Behavior Analysis (ABA)	**X**				
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					*OC/HCA/State*
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist	**X**				
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					*Drug Medi-Cal*
ER-SUD Consultation	**X**				
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					*DHCS*
Residential (Detox/Rehab)					*Drug Medi-Cal*
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					

	Physician		Hospital		Other
Professional Component	X				
Facility Technical Component (hospital & free-standing centers)			X		
Nutritional Dietetic Counseling / Medical Nutrition Therapy	X				
Nutritional Products					
Total Parenteral Nutrition (TPN)					*DHCS PBM***
Total Parenteral Nutrition (TPN) supplies and pumps			X		
Enteral Nutrition products included in the DHCS Enteral Nutrition product list					*DHCS PBM***
Enteral Nutrition Supplies and Pumps	X				
Other Nutrition Products when not covered by DHCS's PBM	X				
Obstetrical Care					
Outpatient diagnostic services	X				
Inpatient professional component	X				
Inpatient facility component			X		
Emergent diagnostic (OB Unit)			X		
Ultrasound	X				
Perinatal care	X				
Perinatal Support Services	X				
Fetal Monitoring					
Professional component	X				
Facility component			X		
Occupational Therapy	*- See Rehabilitation -*				
Orthotics	X				
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	X				
Facility component			X		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	*- See Medication -*				
Physical Therapy	*- See Rehabilitation -*				
Physician Services					
Inpatient	X				
Outpatient (including Revenue Code 510)	X				
Podiatry Services	X				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	X				
Immunizations (Ages 0-18 years)					
Vaccine					*VFC (Vaccines for Children Program)*

	Physician		Hospital		Other
Administration fee	X				
Immunizations (19 years and over)					
Vaccine billed by a Non-Pharmacy provider (inclusive of Medi-Cal administration fee)	X				
Vaccine billed by a Pharmacy					*DHCS PBM***
Adult Periodic Health Exams	X				
Prosthetic Devices					
Surgical implantation	X				
Surgically implanted device/prosthetic			X		
Non-implanted device/prosthetic	X				
Radiation Therapy					
Professional component – (codes 77000-77799: modifier 26)	X				
Facility component			X		
Radiology Services	*- See Diagnostic Services -*				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	X				
Inpatient facility component			X		
Outpatient professional component[1]	X				
Outpatient facility component[1]	X				
Long Term Care Facility	X				
Skilled Nursing Facility					
Custodial – Long Term Care	*- See Long Term Care Services -*				
Short stay	*- See Hospitalization -*				
Speech Therapy	*- See Rehabilitation -*				
Transgender Services					
Professional component	X				
Facility component			X		
Termination of Pregnancy					
Professional component (including Mifepristone/RU-486)	X				
Facility component			X		
Transplants - Including Procurement					
Organ Transplants Evaluations	X				
Organ Transplants	X				
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	X				
Facility Component			X		
Transportation (includes ambulance)					
Emergency			X		
Non-emergency medical transportation (NEMT)			X		
Non-Medical transportation (NMT)			X		
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					*OC HCA Responsibility*

	Physician		Hospital		Other
Non-DOT TB Treatment provided by OC HCA	X				
Non-DOT TB Treatment provided by non-OC HCA Provider	X				
Vision Care					
Routine adult and child eye refraction examination	X				
Contact lenses	X				
Lenses and frames	X				
Argon laser trabeculoplasty	X				
Intraocular lens - surgically implanted			X		
Ophthalmological services	X				
Prosthetic eye	X				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim.	X				
Facility component including all Special Care Center services billable on a facility claim.			X		
Maintenance and Transportation*					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***

*CCS specific services are paid per Article 9.
** The effective date for change of responsibility to DHCS PBM is subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx. If the transition is delayed, the responsibility for these services shall remain with HMO until such transition takes place.

[1] *Services are the responsibility of MTP if provided under the MTP program*

[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*

ATTACHMENT E – Amendment V
Capitation Rates

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

I. Temporary Assistance for Needy Families (TANF) and Seniors and Persons with Disabilities (SPD)
Effective July 1, 2019 through March 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
TANF					
	00-00 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	01-14 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	15-18 F	[redacted]	[redacted]	[redacted]	[redacted]
	15-18 M	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]	[redacted]

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
SPD					
	00-00 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	01-14 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	15-18 F	[redacted]	[redacted]	[redacted]	[redacted]
	15-18 M	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]	[redacted]

II. TANF and SPD
Effective April 1, 2021 through June 30, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
TANF					
	00-00 M & F	[redacted]	[redacted]	N/A	[redacted]
	01-14 M & F	[redacted]	[redacted]	N/A	[redacted]
	15-18 F	[redacted]	[redacted]	N/A	[redacted]
	15-18 M	[redacted]	[redacted]	N/A	[redacted]
	19-39 F	[redacted]	[redacted]	N/A	[redacted]
	19-39 M	[redacted]	[redacted]	N/A	[redacted]
	40-64 M & F	[redacted]	[redacted]	N/A	[redacted]
	65- M & F	[redacted]	[redacted]	N/A	[redacted]

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
SPD					
	00-00 M & F	[redacted]	[redacted]	N/A	[redacted]
	01-14 M & F	[redacted]	[redacted]	N/A	[redacted]
	15-18 F	[redacted]	[redacted]	N/A	[redacted]
	15-18 M	[redacted]	[redacted]	N/A	[redacted]
	19-39 F	[redacted]	[redacted]	N/A	[redacted]
	19-39 M	[redacted]	[redacted]	N/A	[redacted]
	40-64 M & F	[redacted]	[redacted]	N/A	[redacted]
	65- M & F	[redacted]	[redacted]	N/A	[redacted]

III. Adult Expansion Members (MCE)
Effective July 1, 2019 through January 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
MCE					
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]	[redacted]

IV. MCE
Effective February 1, 2021 through March 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
MCE					
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]	[redacted]

V. MCE
Effective April 1, 2021 through June 30, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation*	Total Capitation
MCE					
	19-39 F	[redacted]	[redacted]	N/A	[redacted]
	19-39 M	[redacted]	[redacted]	N/A	[redacted]
	40-64 M & F	[redacted]	[redacted]	N/A	[redacted]
	65- M & F	[redacted]	[redacted]	N/A	[redacted]

VI. Supplemental Capitation

Behavioral Health (BHT)
Effective July 1, 2019 through December 31, 2020

Age in years and Gender Group	Supplemental Capitation
0-6 M&F	[redacted]
7-20 M&F	[redacted]

Behavioral Health (BHT)
Effective January 1, 2021 through June 30, 2021

Age in years and Gender Group	Supplemental Capitation
0-6 M&F	[redacted]
7-20 M&F	[redacted]

Hepatitis C (HEP C)
Effective July 1, 2019 through December 31, 2020

Type	Supplemental Capitation
Non 340B	[redacted]
340B	[redacted]

Hepatitis C (HEP C)
Effective January 1, 2021 through March 31, 2021

Type	Supplemental Capitation
Non 340B	[redacted]
340B	[redacted]

Whole Child Model Members
Effective July 1, 2019 through June 30, 2021

Type	Administrative Services Capitation
CCS eligible Members assigned to HMO	[redacted]

* If the effective date for the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx is delayed, the current Pharmacy capitation rates shall continue until the transition takes place or June 30, 2021, whichever occurs first.

ATTACHMENT E-2 -AMENDMENT V

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 payments to HMO which HMO agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay HMO an administrative fee to administer such Prop 56 payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Medical Group or Provider who is contracted with HMO to provide Medi-Cal services to CalOptima members assigned to HMO. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    b. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    c. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. HMO shall administer the Prop 56 payment in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. HMO shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by HMO to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 payment funding for the initial payments required to be paid by HMO for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by HMO, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by CalOptima in order for

it to fulfill state and federal obligations related to the Prop 56 payments, CalOptima will reimburse HMO for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by HMO more than one year after the date of service.

4. HMO shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by HMO.

5. On a monthly basis, HMO must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by HMO or by HMO's delegated entities and subcontractors at HMO's direction. Reports shall include all supplemental Prop 56 payments made during the month. HMO must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. HMO, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay HMO a two percent (2%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 payments have been made by HMO to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, CalOptima shall reconcile the remaining medical cost plus a 2% administrative component based on confirmed Prop 56 payments and remit to the HMO no later than the twentieth (20th) calendar day of the current month based upon prior month's data.

7. CalOptima's obligation to pay HMO any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 payments. In no event shall CalOptima be obligated to pay Administrative Fees to HMO if CalOptima has not received funding for administration of the Prop 56 payments from DHCS.

8. HMO shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. HMO acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 payments identifies invalid payments, HMO shall return such Prop 56 payments to CalOptima immediately upon notice from CalOptima.

10. HMO agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 payments.

11. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 payments.

12. To ensure proper implementation of the supplemental Prop 56 payments, HMO shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 payments to CalOptima, CalOptima will continue to make Prop 56 payments to HMO, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

15. Notwithstanding other provisions of this Attachment E-2, effective July 1, 2020, CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

HMO shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to HMO prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

HMO shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to HMO. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by HMO no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	$77.00
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	$80.00
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	$77.00
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	$83.00
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1-year-old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-19 years old)	$27.00

ATTACHMENT E-3 – AMENDMENT V
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and HMO, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. HMO must reimburse Eligible Non-Contracted Providers a differential totaling up to [redacted] that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to HMO, and HMO agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay HMO an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. "Eligible Non-Contracted Provider" shall mean a Provider who is not contracted with HMO to provide GEMT services or a Provider who is contracted with HMO for transportation services, but not contracted with HMO to provide GEMT services to CalOptima Medi-Cal members.

    b. "Qualifying Services" shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. HMO shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to [redacted] for Qualifying Services furnished by Eligible Non-Contracted Providers. HMO is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the HMO within one year after the date of service.

3. HMO shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. HMO is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a [redacted] administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to HMO based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. HMO shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to HMO by means of a Notice to this Contract.

10. Notwithstanding other provisions of this Attachment E-3, effective July 1, 2020, CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program pursuant to Section 2.7.18 of the Contract.

Attachment E-4 – Amendment V

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to HMO for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of CalOptima Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

   1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
   - Member is enrolled in the HHP;
   - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the HMO, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the HMO;
   - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
   - If applicable, the HMO paid the provider for the HHP core services; and
   - The HMO authorized such HHP core services.

   [redacted] PMPM (January – June 2020)
   [redacted] PMPM (July – December 2020)
   [redacted] PMPM (January – December 2021)

2. Engagement Activities Supplemental Capitation Payment

   2.1 Subject to Section 2.2 of this Attachment E-4, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
   - The HMO conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
   - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
   - If applicable, the HMO authorized and paid the provider for such engagement

   [redacted] PMPM (January – June 2020)
   [redacted] PMPM (July – December 2020)
   [redacted] PMPM (January – December 2021)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. HMO shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15th) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

15. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute:

1. An Amended and Restated Medi-Cal Health Network Contract with Kaiser Foundation Health Plan, Inc., incorporating language changes, effective July 1, 2019 through June 30, 2021; and
2. Amendments incorporating all changes made in the Health Network contracts since July 1, 2019, including certain operational requirements and revisions to the capitation rates

Background

Kaiser Foundation Health Plan Inc. (Kaiser) participates in CalOptima's Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization (HMO) Health Network model. CalOptima's health network contracts are renewed on an annual basis each July, subject to Board approval. On June 6, 2019, the CalOptima Board authorized an Amended and Restated Contract with all Health Networks. The Board has approved five (5) Amendments to the Amended and Restated Health Network Contract since that time.

Kaiser did not, however, execute the Amended and Restated Contract or the five (5) subsequent Amendments and, instead, engaged CalOptima staff in a series of discussions regarding certain contract terms. The Board authorized extensions of the existing contract on August 6, 2020, October 1, 2020, November 5, 2020, and December 3, 2020, to accommodate continued contract discussions. The most recent extension is effective through February 4, 2021.

Discussion

Kaiser and CalOptima staff have had extensive discussions and have come to an agreement regarding the terms of the Amended and Restated Contract. The document has been revised and some terms updated to address legacy language and operational requirements addressing Kaiser's business model. Board authorization to execute the Amended and Restated Contract effective July 1, 2019 through June 30, 2021 is now requested. Authorization is also sought to execute Amendments I through V, which include but are not limited to:

- Operational requirements including extending funding for the Health Homes Program
- Extension of Behavioral Health Treatment and Hepatitis C supplemental capitation payments
- Revised capitation rates reflecting a reduction for Medi-Cal Expansion members
- Removal of pharmacy risk and capitation upon implementation of the carve-out of the pharmacy benefit by the State

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The revised capitation rates for Medi-Cal Expansion members will be effective February 1, 2021, and the Amended and Restated Contract will be in effect through June 30, 2021, consistent with CalOptima's contracts with the other Health Network.

Fiscal Impact

The recommended actions to retroactively enter into the Board-approved Amended and Restated HMO Health Network Contract with Kaiser effective July 1, 2019, through June 30, 2021, and amendments incorporating operational provisions and revised capitation rates are budgeted items. Funding for the contract and related amendments has been included in the Board-approved Fiscal Year (FY) 2019-20 and FY 2020-21 Operating Budgets.

Rationale for Recommendation

Authorization to execute the Amended and Restated Medi-Cal Health Network Contract and update capitation rates will ensure that Kaiser is operating under the current contractual terms and conditions as required by CalOptima's regulators and operational requirements, and will implement the rebased capitation rates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020; "Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term," which includes the following attachments:
   - Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term"
   - Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment"
3. Previous Board Action dated June 4, 2020; "Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-risk, and Physician-Hospital Consortium Health Network Contracts"
4. Previous Board Action dated April 2, 2020; "Consider Actions Related to Coronavirus (COVID-19) Pandemic"
5. Previous Board Action dated March 5, 2020; "Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation"
6. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program"

7. Previous Board Action dated September 5, 2019; "Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transportation (GEMT)"
8. Previous Board Action dated June 27, 2019; "Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network"
9. Previous Board Action dated June 6, 2019; "Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates"

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

Contact

Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, December 3, 2020.

Background

Kaiser Foundation Health Plan, Inc. (Kaiser) participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020. As of the last Board of Directors' Meeting, on October 1, 2020, it was determined that review of certain provisions in the Amended and Restated contract was still in progress. As such, an additional month-long extension was requested until November 5, 2020.

Discussion

The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Proposition 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by November 5, 2020, additional time is required to fully explore whether the parties will be able to resolve and finalize the remaining issues. Staff has requested an additional month-long extension of the current

Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract Amendments to the Board for approval at the December 3, 2020 meeting, Staff requests that the Board approve extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to authorize extension of the current Kaiser Health Network Contract to through December 3, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through December 3, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"
3. Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term.

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

CalOptima
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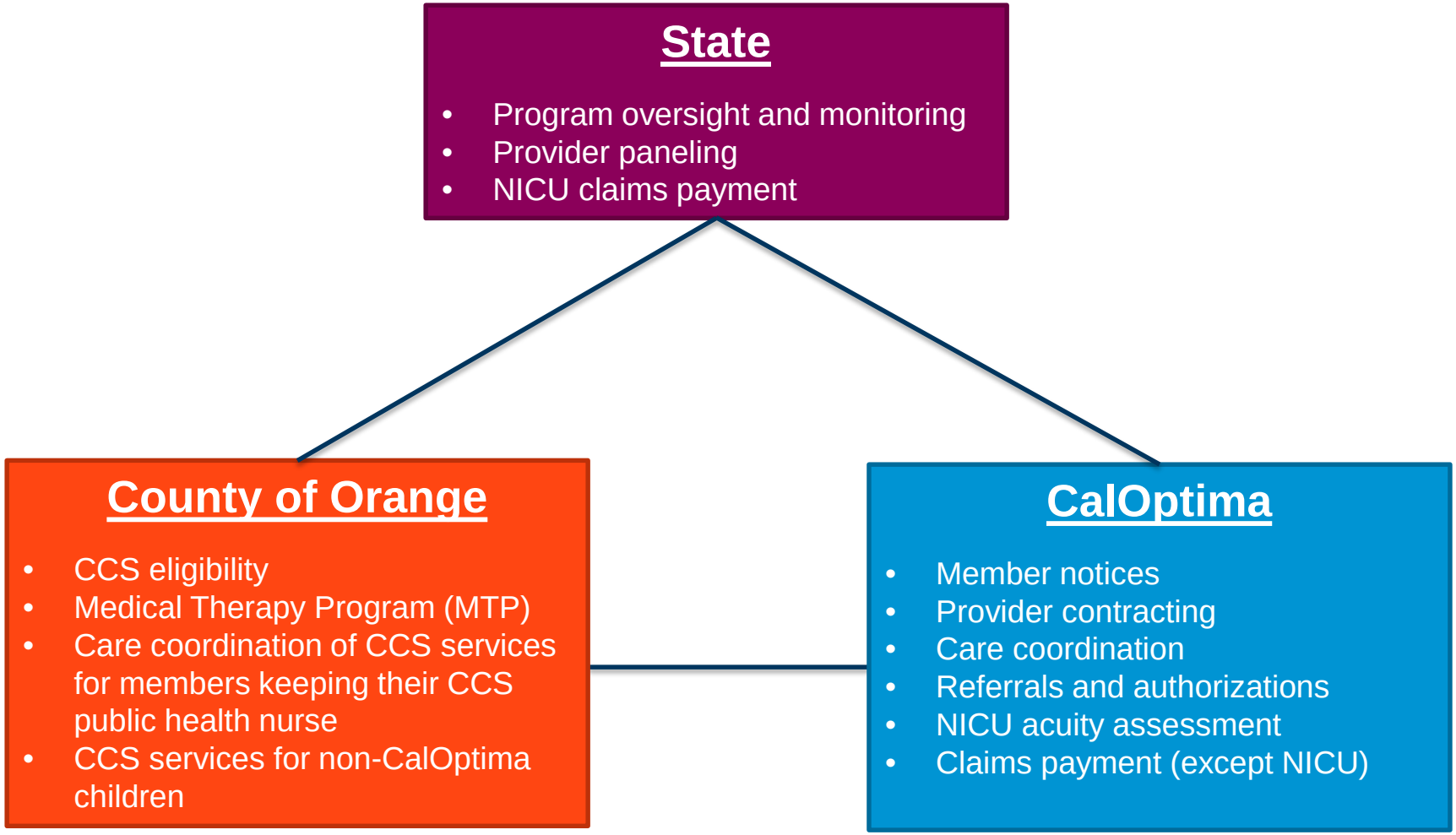
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

CalOptima
A Public Agency
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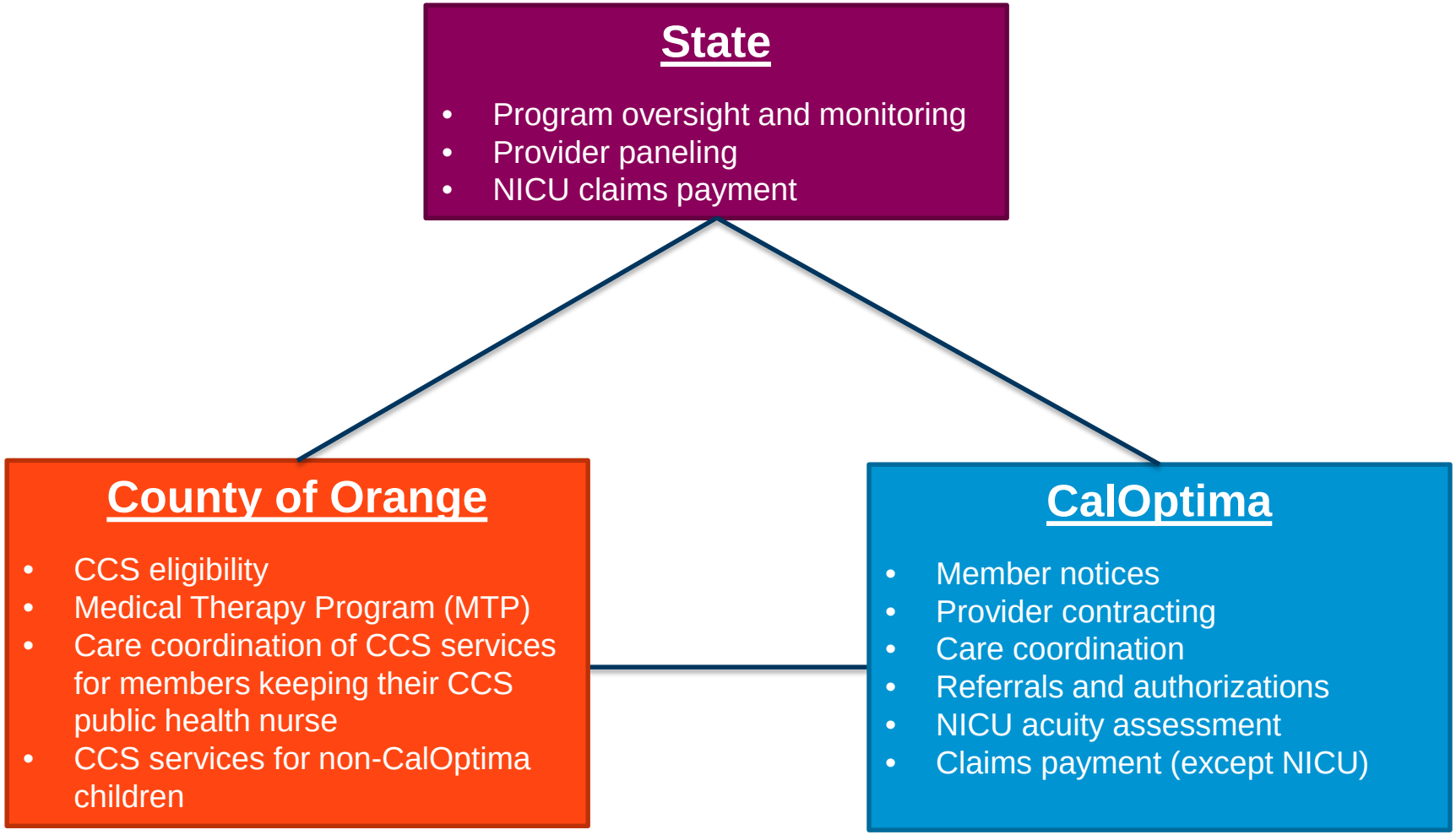
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Back to Item
Back to Agenda
Back to Item

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

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delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

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C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

    a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

    b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact

With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation

These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

Concurrence

Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Ratify the amendment to the current Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020.

Background
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020.

Discussion
The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Prop 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by September 30, 2020, it will take another thirty (30) days to finalize these issues. Kaiser has requested an additional thirty (30) day extension of the current Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract

Amendments to the Board for approval at the November 5, 2020 meeting, Staff requests that the Board ratify the extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to amend the current Kaiser Health Network Contract to extend the term through November 5, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through November 5, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

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Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

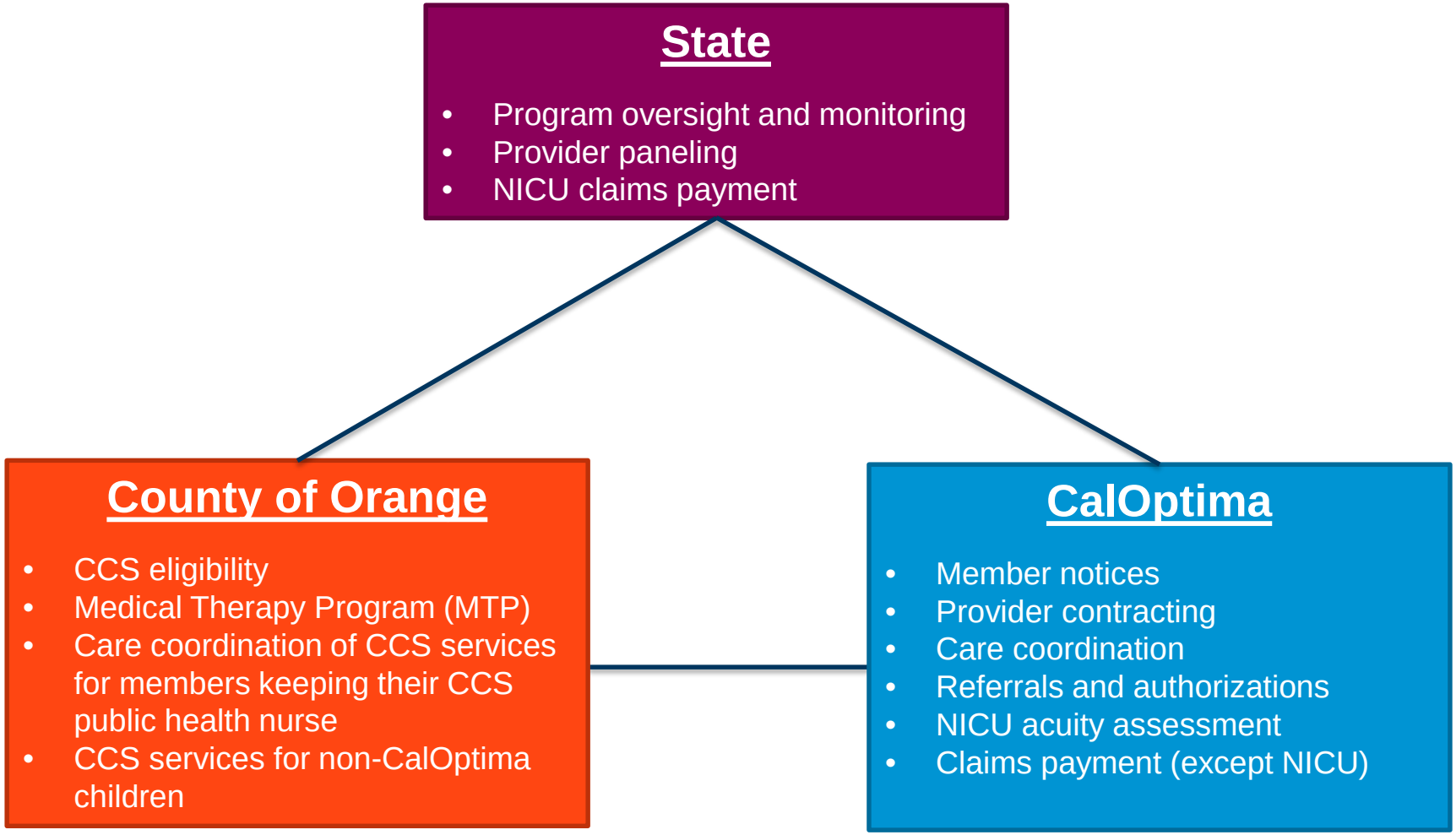
Program Implementation

Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

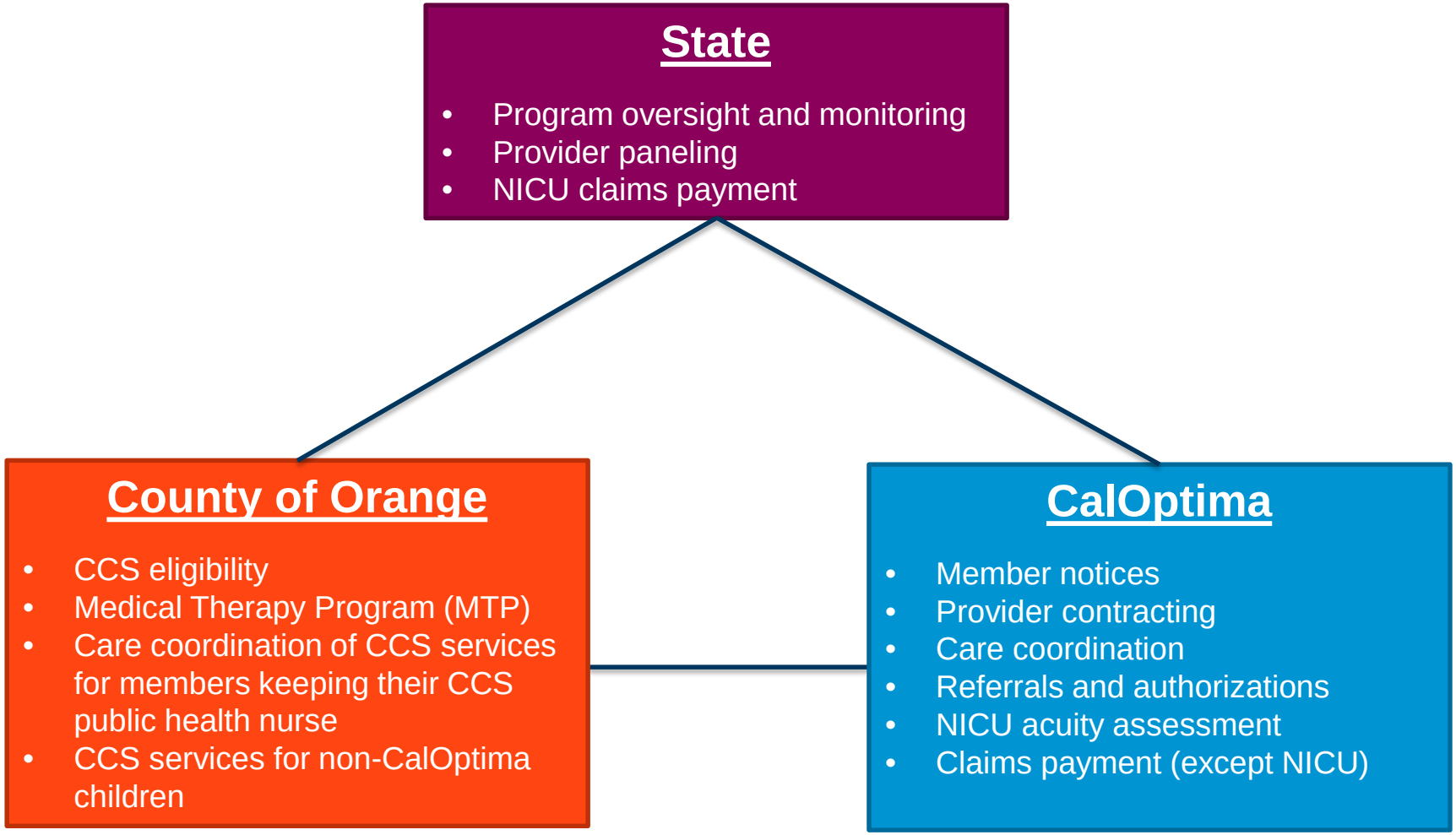
Program Implementation

Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

CalOptima
A Public Agency
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

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delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

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C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact

With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation

These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

Concurrence

Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

1. Ratify amendments to the Medi-Cal health network contracts, except AltaMed Health Services Corporation, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including

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receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the Medi-Cal health networks, except AltaMed Health Services Corporation, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

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Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

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IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

RFP Summary

RFP	Total Received	Total Recommended
1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

3. Increase Access to Medication-Assisted Treatment ($6 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Internal Projects ($2.4 million)

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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PACE
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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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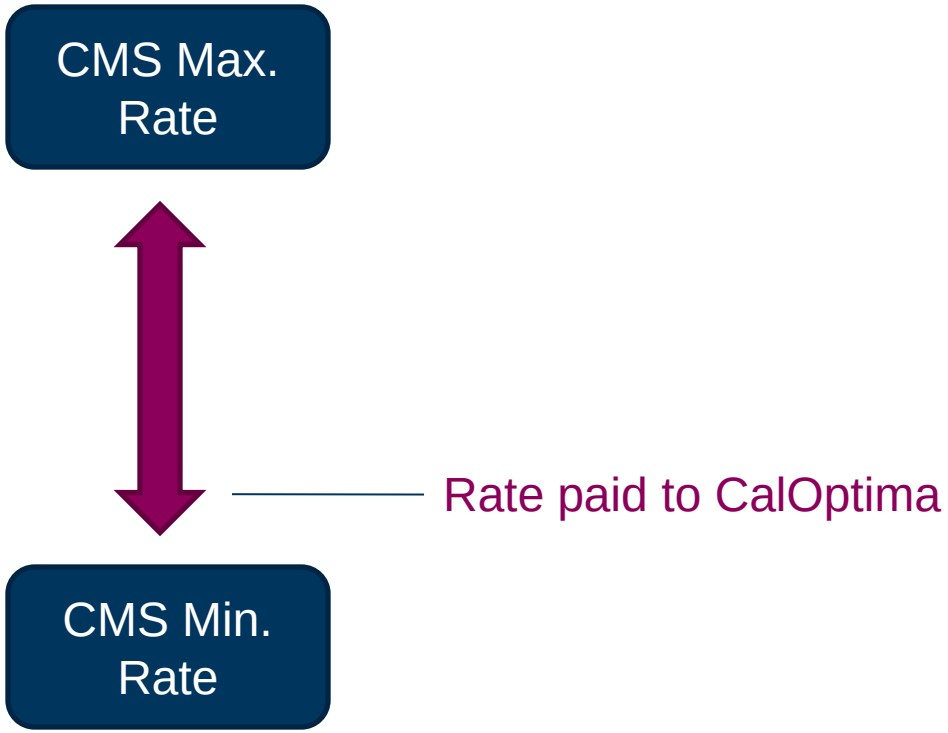
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

As of 5/31/2017

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

As of 5/31/2017

IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

As of 5/31/2017

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IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of $21.1 million for the Department of Health Care Services (DHCS)-approved and Board-approved priority areas; and
2. Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

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Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

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Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

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Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

/s/ Michael Schrader — **Authorized Signature**

8/29/2018 — **Date**

IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

Strengthened System of Care

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - ➢ Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - ➢ Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
   a. Amend the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as include all subcontracting requirements of the California Department of Health Care Services (DHCS);
   b. Amend the Business Associate Agreements, as necessary, for network data sharing; and
2. Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019.

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

HHP Eligible Members and HHP Enrollment

Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 30,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. HHP eligible members who are currently in Whole Person Care Pilot program can also elect to enroll in HHP, however services provided under both programs cannot be duplicated. CalOptima's dually eligible

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members can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

HHP Network Delivery Model
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. For HHP, CalOptima can leverage existing infrastructure to incorporate the new HHP services.

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

Health Network Contracts
In order to implement HHP, CalOptima health network contracts will need to be amended, effective January 1, 2020, to include providing HHP services, expectations of CB-CME responsibilities, guidelines for information and data sharing, as well as HHP training. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate.

Amendment to County Behavioral Health MOU
Pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination. The Behavioral Health MOU between CalOptima and the County of Orange has been amended to reflect that CalOptima and the County agree to coordinate appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and adjust operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. Currently, CalOptima's policies impacted by HHP requirements have been submitted to DHCS as part of the HHP regulatory submission requirements. Once CalOptima receives the feedback from DHCS, CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Additionally, CalOptima staff will continue to collaborate with Orange County HCA, Health Networks, and other stakeholders for Phase II of the Health Homes Program for SUD, SMI, and homelessness consistent with requirements as specified by DHCS.

Fiscal Impact
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 14

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

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

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

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Medi-Cal Health Homes Program
Program Guide
7/01/19

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

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B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Ratify Medi-Cal health network contract amendments, excluding those involving the CHOC Physicians Network, to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year (SFY) 2018-19 and all future extensions thereafter provided the State of California continues the enhanced Proposition 56 payments to CalOptima.

Background/Discussion

Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through either direct communication or an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance and rates are not provided until after the fiscal year begins; requiring MCPs to develop initial catch up and ongoing payment distribution processes.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal health network contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance had not been released as of May 8, 2019. Even though the final APL for the current fiscal year had not been released, DHCS instructed MCPs to distribute initial catch up SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019. In a separate Board action, CalOptima staff requested approval of a standardized annual Proposition 56 provider payment process.

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The standardized annual Proposition 56 provider payment process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. To continue Proposition 56 provider payments, Staff amended health network contracts to the extend the dates of service eligible for Proposition 56 payments into the current SFY and to ensure payments are made within with the timeframes based on DHCS guidance. CalOptima staff will seek subsequent Board action for further action if any future DHCS Proposition 56 requirements warrant significant changes to the standardized annual process.

Fiscal Impact

The recommended action to ratify amendments to Medi-Cal health network contracts, excluding those involving the CHOC Physicians Network, related to Proposition 56 is projected to be budget neutral to CalOptima. While total disbursement of Proposition 56 funding is dependent upon timely and accurate claims submissions from eligible providers, DHCS has projected Fiscal Year 2018-19 funding at approximately $102 million. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence

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

Attachments

1. Conflicts of Interest List: Medi-Cal Health Networks
2. June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment
3. November 1, 2018 CalOptima Board Action Agenda Referral Report Item 10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

/s/ Michael Schrader — *6/20/2019*
Authorized Signature — **Date**

Conflicts of Interest List: Medi-Cal Health Networks

Name	Address	City	State	Zip Code
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CHOC Health Alliance	1120 West La Veta Ave., #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to enter into contract amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, for AltaMed Health Services, AMVI Care Health Network, CHOC Physicians Network, Children's Hospital of Orange County, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Kaiser Foundation Health Plan, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan and United Care Medical Group to continue to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June

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7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September 26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, health network contracts need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with Medi-Cal health networks to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Children's Hospital of Orange County	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 East Walnut Street, 2nd Floor	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an Amended and Restated Health Network Contract with Kaiser Foundation Health Plan, Inc., effective June 30, 2019 that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
b) Amended capitation rates for assigned members effective July 1, 2019.

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid Managed Care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to: emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

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Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The anticipated Medi-Cal revenue for FY 2019-20 is projected to be sufficient to cover the costs of the recommended action to amend capitation rates for assigned members effective July 1, 2019. Management has included projected expenses associated with the extended contracts in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — **Authorized Signature**

5/29/2019 — **Date**

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Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

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1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CalOptima Board Action Agenda Referral

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

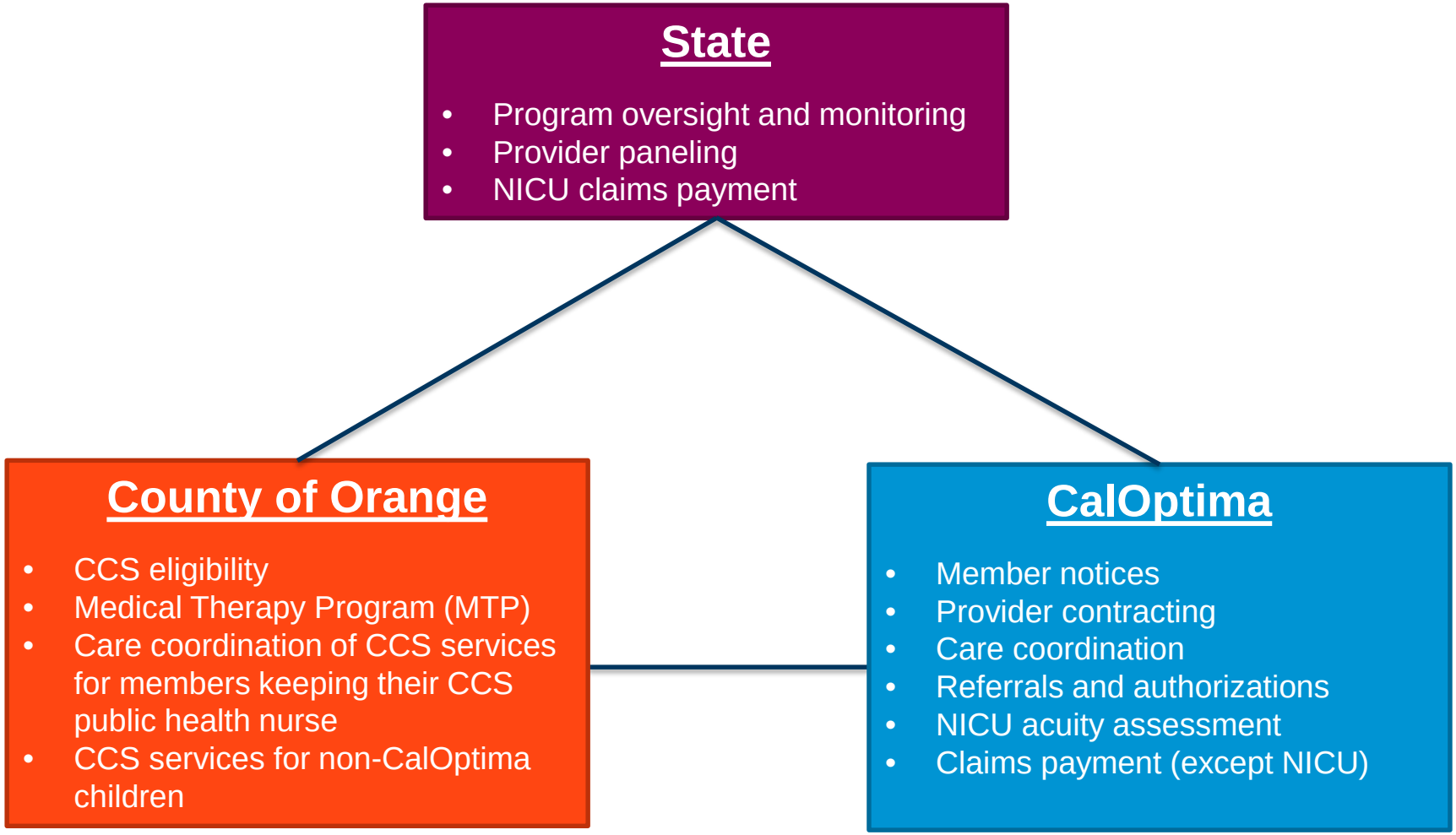
Program Implementation

Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Authorizing the Extension of and Other Amendments to the CalOptima Medi-Cal Full-Risk Health Maintenance Organization, Shared-Risk Group, and Physician-Hospital Consortium Health Network Contracts Except those Affiliated with Kaiser Foundation Health Plan, Inc., and Ratification of the Delegation Agreements Related to Those Contracts

Contacts

Ladan Khamseh, Chief Operating Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), and Physician-Hospital Consortium (PHC) Health Network contracts, except those Affiliated with Kaiser Foundation Health Plan, Inc. (Kaiser) to:
   a. Extend the term through June 30, 2022;
   b. Revise the Division of Financial Responsibility (DOFR) to transfer financial responsibility for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Private Duty Nursing to CalOptima;
   c. Reflect adjustments to the Health Networks' capitation rates for the DOFR change as well as changes in state funding effective July 1, 2021; and
2. Ratify the Health Network Delegation Agreements, except Kaiser's Delegation Agreement, effective January 1, 2021.

Background

The Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Networks listed below have contracted with CalOptima to provide care to CalOptima Medi-Cal members, and the contracts will expire on June 30, 2021. Renewal of these Health Network contracts will support the stability of CalOptima's contracted provider network.

Full Risk HMO:
Heritage Provider Network, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk Group:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
Talbert Medical Group

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United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

Discussion
Staff recommends extending the above Health Network contracts for one year through June 30, 2022. Extension of the Health Network contracts is essential to ensuring that members assigned to the Health Networks have access to covered health care services.

Staff recommends revising the DOFR to realign the financial responsibility for EPSDT private duty nursing to CalOptima. In 2019, the Department of Health Care Services (DHCS) transferred the responsibility for California Children's Services (CCS) to Medi-Cal Managed Care and the utilization for EPSDT private duty nursing was greater than anticipated, and overconcentrated in certain networks. Since this change (applicable to all Health Networks except Kaiser), the cost for EPSDT private duty nursing has been of concern to the Health Networks. CalOptima staff recommends that, rather than delegating this financial responsibility to the Health Networks, CalOptima bear the cost for these services. Health Networks will retain responsibility for coordinating and authorizing private duty nursing services to ensure access is available for all members.

In addition to the financial impact of the change to the DOFR, member capitation rates to the Health Networks will be adjusted pursuant to the updated Fiscal Year 2021–22 State of California budget and funding, effective July 1, 2021.

The Delegation Agreement delineates delegated administrative services that the Health Networks are responsible to perform. This agreement is required for the National Committee for Quality Assurance (NCQA) audits, and DHCS requirements. The ratification is being sought as the Health Networks signed the Delegation Agreement in April 2021, in order to meet the NCQA audit submission deadline.

To ensure continued access to covered services for Health Network members and compliance with NCQA and DHCS requirements, staff recommends approving amendments to extend the above Health Network contracts through June 30, 2022, revisions to the DOFR, updates to the capitation rates, and ratification of the Delegation Agreement.

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Fiscal Impact

The recommended action to amend Medi-Cal Health Network contracts to extend the term through June 30, 2022 and ratify the Delegation Agreement is not expected to have a fiscal impact.

The recommended action to reflect adjustments to the Health Networks' capitation rates for the DOFR change are as follows:

Medi-Cal Classic: Aggregate rate increase of 1.44% or $3.5 million for professional capitation and 5.4% or $5.9 million for facility capitation to account for updated capitation assumptions, as well as increases to CalOptima FFS contracts. CalOptima will also assume EPSDT private duty nursing risk effective July 1, 2021 estimated at $814,000 annually.

Medi-Cal Expansion (MCE): Decrease of 9.0% or $27.6 million for professional capitation and 12.0% or $20.7 million for facility capitation to continue glidepath to revised rates commensurate with underlying risk. The net shared risk pool impact is a $7.8 million decrease. Aggregate decrease to MCE capitation expenses and associated shared risk pool is $56.1 million.

Whole Child Model: Initial professional and facility capitation rates were revised based on analysis conducted on more current utilization data. Based on this analysis, increase of 49.7% or $11.8 million for professional capitation, and decrease of 18.3% or $11.9 million for facility capitation annually. CalOptima will also assume EPSDT private duty nursing risk effective July 1, 2021estimated at $17.9 million annually. With this change, CalOptima is reducing the amount of dollars flowing through the annual risk corridor reconciliation with the Health Networks.

Costs associated with the recommended action to transfer financial responsibility for EPSDT private duty nursing to CalOptima and adjusted capitation rates effective July 1, 2021, have been included in the proposed CalOptima Fiscal Year (FY) 2021-22 Operating Budget pending Board approval.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network, ensure continued access to care for members assigned to Health Networks, and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Action
2. Medi-Cal Full-Risk HMO, SRG, and PHC Health Network Contract Amendment Template
3. Delegation Acknowledgement and Acceptance Agreement (Delegation Agreement)
4. Medi-Cal Full-Risk HMO, SRG, and PHC Health Network Contract Template and Amendments

/s/ Richard Sanchez — *05/26/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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AMENDMENT VIII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VIII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician wish to enter into this amendment to extend the term of the Contract and revise the Division of Financial Responsibilities and capitation rates.

NOW, THEREFORE, the parties agree as follows:

1. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

   "15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; –(II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2022."

2. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment VIII.

3. Attachment E shall be deleted in its entirety and replaced with the attached Attachment E – Amendment VIII "Capitation Rates".

4. Attachment E-1 shall be deleted in its entirety and replaced with the attached Attachment E-1 – Amendment VIII "Capitation Rates for Adult Expansion Members".

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment VIII:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE

DATE

DATE

ATTACHMENT A – AMENDMENT VIII
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)					***CalOptima (Claims)***
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		

	Physician		Hospital		Other
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)'s***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				

	Physician		Hospital		Other
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				

	Physician		Hospital		Other
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***

	Physician		Hospital		Other
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation *					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] *Services are the responsibility of MTP if provided under the MTP program.*					
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*					

ATTACHMENT E – AMENDMENT VIII
Capitation Rates

Effective July 1, 2021

ATTACHMENT E-1 – AMENDMENT VIII
Capitation Rates for Adult Expansion Member

Effective July 1, 2021

DELEGATION ACKNOWLEDGEMENT AND ACCEPTANCE AGREEMENT

_____ ("Delegate") agrees to perform the delegated services, in accordance with the responsibilities set forth in the attachment to this Delegation Acknowledgment and Acceptance Agreement ("Agreement"), for the following CalOptima Program(s) with respect to CalOptima members assigned to the Delegate's network:

_____Medicaid Program (Medi-Cal)
_____Medicare Advantage Program (OneCare)
_____Cal MediConnect Program (OneCare Connect)

The purpose of the Delegation Grid, which is attached hereto and incorporated herein by reference, is to specify the activities delegated by CalOptima under the Agreement with respect to: (1) Quality Improvement, (2) Population Health Management, (3) Network Management, (4) Utilization Management, (5) Credentialing and Recredentialing, (6) Member Experience, (7) Claims, (8) Provider Complaint, and/or (9) Medicaid, as applicable. All delegated activities shall be performed in accordance with currently applicable NCQA accreditation standards, State and Federal statutory, regulatory, and sub-regulatory requirements, and CalOptima Policies and contractual requirements, including CalOptima's contract(s) with its regulator(s) and CalOptima's contract(s) with the Delegate, (collectively, "Standards and Requirements"), as modified from time to time. This Agreement shall not be construed as limiting or circumscribing the Delegate's obligations to comply with all applicable Standards and Requirements when performing delegated activities for applicable CalOptima Program(s). Further, the Delegate shall comply with the most stringent applicable Standards and/or Requirements for such delegated activities.

Delegate agrees to be accountable for all responsibilities delegated by CalOptima and oversight of any sub-delegated functions or activities. CalOptima will maintain oversight of delegated activities to ensure compliance with applicable Standards and Requirements. Any sub-delegation by Delegate of the activities or functions set forth in this Agreement shall require prior written approval from CalOptima and shall comply with all terms and conditions of this Agreement, including but not limited to applicable Standards and Requirements. The Delegate shall conduct risk assessments, at least annually, ongoing Monitoring, and Audit of sub-delegates to ensure compliance. CalOptima retains the right to conduct CalOptima's own risk assessments, ongoing Monitoring, and Audits of sub-delegate's performance of sub-delegated functions or activities.

Delegate agrees to submit reports, data, and documentation to CalOptima as identified in the Delegation Grid and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Timely and Appropriate Submission Grid - Supplemental Attachment (collectively, "CalOptima Reporting Policy"). See CalOptima Reporting Policy for reporting descriptions and frequency, and manner of submission to applicable CalOptima Departments. CalOptima Reporting Policy may be modified from time to time pursuant to CalOptima Board approval. Delegate acknowledges it has additional reporting responsibilities and other obligations to CalOptima as specified in applicable CalOptima Policies or contractual requirements (including the Contract for Health Care Services between CalOptima and the Delegate) that are not related to this Agreement.

CalOptima shall perform oversight, including Audit(s) and ongoing Monitoring, of the functions and responsibilities, processes, and performance of a delegated entity and its delegated services, in accordance with CalOptima Policies, including but not limited to CalOptima Policy GG.1619: Delegation

Oversight. Failure by Delegate to comply with applicable Standards and/or Requirements may lead to further action, in accordance with CalOptima Policy HH.2005: Corrective Action Plan and CalOptima Policy HH.2002: Sanctions. CalOptima may amend or revoke any of the delegated responsibilities set forth in this Agreement.

For purposes of this Agreement, the term “Audit” or “Auditing” means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications. The term “Monitoring Activities” or “Monitoring” means regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

CalOptima retains the right to approve, suspend and terminate individual practitioners, providers and sites from the Delegate’s network relative to CalOptima’s Medi-Cal, OC, and/or OCC Program(s), even if CalOptima delegates credentialing and re-credentialing decision-making to the Delegate. CalOptima has the right to make the final determination of such participation in the Delegate’s network.

Upon request, CalOptima shall provide to the Delegate clinical performance and/or member experience data per CalOptima Policy GG.1637: Assessing Member Experience. The parties agree to comply with the terms and conditions of the Business Associate Agreement between CalOptima and the Delegate.

This Agreement shall become effective [Insert effective date] superseding prior Delegation Acknowledgement and Acceptance Agreements and shall remain in effect for the duration of the Contract for Health Care Services between CalOptima and Delegate, or until superseded by subsequent agreement.

For Delegate:	For CalOptima:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 1: Quality Improvement (QI)				
Section 1.1: Program Structure and Operations				
1.1.1	QI Program Structure	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.1.2	Annual Work Plan	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.1.3	Annual Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.1.4	QI Committee Responsibilities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 1.2: Health Services Contracting				
1.2.1	Practitioner Contracts	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.2.2	Provider Contracts	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 1.3: Continuity and Coordination of Medical Care				
1.3.1	Identifying Opportunities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.3.2	Acting on Opportunities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.3.3	Measuring Effectiveness	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
1.3.4	Transition to Other Care	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 1.4: Continuity and Coordination Between Medical Care and Behavioral Healthcare				
1.4.1	Data Collection	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.4.2	Collaborative Activities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.4.3	Measuring Effectiveness	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 1.5: Delegation of QI				
1.5.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.3	Review of QI Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
1.5.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

(Remainder of this page intentionally left blank)

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 2: Population Health Management (PHM)				
Section 2.1: Population Health Management Strategy				
2.1.1	Strategy Description	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.1.2	Informing Members	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 2.2: Population Identification				
2.2.1	Data Integration	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.2.2	Population Assessment	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.2.3	Activities and Resources	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.2.4	Segmentation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 2.3: Delivery System Supports				
2.3.1	Practitioner or Provider Support	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.3.2	Value-based Payment Arrangements	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 2.4: Wellness and Prevention				
2.4.1	Frequency of Health Appraisal Completion	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.4.2	Topics of Self-Management Tools	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 2.5: Complex Case Management				
2.5.1	Access to Case Management	Yes	The Delegate helps members with multiple or complex conditions to obtain access to care and services and coordinates their care. The Delegate has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral. 2. Discharge planner referral. 3. Member or caregiver referral. 4. Practitioner referral. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.5.2	Case Management Systems	Yes	The Delegate uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management. 2. Automatic documentation of the staff ID and date and time of action on the case or when interaction with the member occurred. 3. Automated prompts for follow-up, as required by the case management plan. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
2.5.3	Case Management Process	Yes	The Delegate's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of the activities of daily living. 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Initial assessment of life-planning activities. 7. Evaluation of cultural and linguistic needs, preferences, or limitations. 8. Evaluation of visual and hearing needs, preferences, or limitations. 9. Evaluation of caregiver resources and involvement. 10. Evaluation of available benefits.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			11. Evaluation of community resources. 12. Development of an individualized case management plan, including prioritized goals, that considers the member and caregiver goals, preferences, and desired level of involvement in the case management plan. 13. Identification of barriers to a member meeting goals or complying with the plan. 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals. 15. Development of a schedule for follow-up and communication with members. 16. Development and communication of member self-management plans. 17. A process to assess members progress against case management plans for members. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	
2.5.4	Initial Assessment	Yes	The Delegate's complex case management files demonstrate that the Delegate follows its documented processes for: 1. Initial assessment of member health status, including condition specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of the activities of daily living (ADL). 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Evaluation of cultural and linguistic needs, preferences, or limitations. 7. Evaluation of visual and hearing needs, preferences, or limitations. 8. Evaluation of caregiver resources and involvement. 9. Evaluation of available benefits. 10. Evaluation of available community resources. 11. Assessment of life-planning activities. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
2.5.5	Case Management-Ongoing Management	Yes	The Delegate's complex case management files demonstrate that the Delegate follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences, and desired level of involvement in the complex case management program. 2. Identification of barriers to meeting goals and complying with the case management plans. 3. Development of schedules for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals, and modification as needed. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Monthly Case Management Log	CalOptima conducts oversight assessments of the delegated activities including, Audits annually or as often as necessary and ongoing Monitoring.
Section 2.6: Population Health Management Impact				
2.6.1	Measuring Effectiveness	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.6.2	Improvement and Action	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 2.7: Delegation of PHM				
2.7.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
2.7.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.7.3	Review of PHM Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
2.7.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 3: Network Management (NM)				
Section 3.1: Availability of Practitioners				
3.1.1	Cultural Needs and Preferences	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.1.2	Practitioners Providing Primary Care	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.1.3	Practitioners Providing Specialty Care	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.1.4	Practitioners Providing Behavioral Healthcare	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 3.2: Accessibility of Services				
3.2.1	Access to Primary Care	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.2.2	Access to Behavioral Healthcare	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.2.3	Access to Specialty Care	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 3.3: Assessment of Network Adequacy				
3.3.1	Assessment of Member Experience Accessing the Network	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.3.2	Opportunities to Improve Access to Nonbehavioral Healthcare Services	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.3.3	Opportunities to Improve Access to Behavioral Healthcare Services	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 3.4: Continued Access to Care				
3.4.1	Notification of Termination	Yes	The Delegate uses information at its disposal to facilitate continuity of and coordination of medical care across its delivery system. The Delegate notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner. Termination date is the date when the termination becomes effective. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Provider Termination Quarterly Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
3.4.2	Continued Access to Practitioners	Yes	The Delegate shall provide continuity of care for a member involuntarily transitioning between providers or practitioners to prevent the delay or interruption of medically necessary covered services, in accordance with the terms and conditions of CalOptima Policies. The Delegate shall allow for the completion of services, upon member request, in accordance with CalOptima Policies, for the following conditions:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			1. Acute condition, serious chronic condition, pregnancy, terminal illness, or the care of a newborn child between birth through 36 months; or 2. Performance of a surgery or other procedure that is authorized by the Delegate as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the contract's termination date or within 180 calendar days of the effective date of coverage for a newly covered member. The Delegate shall ensure continuation of treatment, upon member request, through the current period of active treatment for acute and chronic conditions not to exceed 12 months, except as provided for Medi-Cal members eligible with the Whole Child Model (WCM) program. The Delegate shall ensure continuation of care, upon member request, for the duration of the pregnancy, which includes the three trimesters and immediate postpartum period. The Delegate shall comply with the following CalOptima Policies: 1. Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services (Medi-Cal) 2. Policy GG.1304: Continuity of Care during Health Network or Provider Termination (Medi-Cal) 3. Policy CMC.6021: Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners (OCC) 4. Policy MA.6021: Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners (OC) Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	
Section 3.5: Physician and Hospital Directories				
3.5.1	Physician Directory Data	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.2	Physician Directory Updates	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.5.3	Assessment of Physician Directory Accuracy	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.4	Identifying and Acting on Opportunities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.5	Searchable Physician Web-based Directory	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and not delegated to the Delegate.
3.5.6	Hospital Directory Data	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.7	Hospital Directory Updates	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.8	Searchable Hospital Web-based Directory	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.9	Usability Testing	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.5.10	Availability of Directories	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 3.6: Delegation of Network Management				
3.6.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.6.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
3.6.3	Review of Delegated Activities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
3.6.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 4: Utilization Management (UM)				
Section 4.1: UM Program Structure				
4.1.1	Written Program Description	Yes	The Delegate has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. The Delegate's UM program description includes the following: 1. A written description of the program structure: a. UM staff member's assigned activities. b. UM staff who have the authority to deny coverage. c. Involvement of a designated physician and designated behavioral healthcare practitioner. d. The process for evaluating, approving, and revising the UM program, and the staff responsible for each step. e. The UM program's role in the QI program, including how the Delegate collects UM information and uses if for QI activities. f. The Delegate's process for handling appeals and making appeal determinations. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior-level physician in UM Program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM Program. 5. The program scope and process used to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. For factors 5 and 6 above, the Delegate's UM program description specifies: a. The UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including: i. How the Delegate develops and selects criteria. ii. How the Delegate reviews, updates and modifies criteria. b. How medical necessity and benefits coverage for inpatient and outpatient services are determined. c. The description of the data and information the Delegate uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision-making process.	CalOptima conducts oversight assessments of the delegated activities including, Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			d. The triage and referral process for behavioral healthcare services (if applicable). e. How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable). Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual Work Plan (ICE) 3. Annual UM Evaluation	
4.1.2	Annual Evaluation	Yes	The Delegate annually evaluates and updates the UM program, as necessary. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities including, Audits annually or as often as necessary and ongoing Monitoring.
Section 4.2: Clinical Criteria for UM Decisions				
4.2.1	UM Criteria	Yes	The Delegate applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Delegate: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs and considers at least the following individual characteristics when applying criteria: a. Age. b. Co-morbidities. c. Complications. d. Progress of treatment. e. Psychosocial situation. f. Home environment, when applicable.	CalOptima conducts oversight assessments of the delegated activities including, Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	
4.2.2	Availability of Criteria	Yes	The Delegate: 1. States in writing how practitioners can obtain UM criteria. 2. Makes the UM criteria available to its practitioners and members upon request. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.2.3	Consistency in Applying Criteria	Yes	At least annually, the Delegate: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 4.3: Communication Services				
4.3.1	Access to Staff	Yes	Members and practitioners can access staff to discuss UM issues. The Delegate provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.4: Appropriate Professionals				
4.4.1	Licensed Health Professionals	Yes	UM decisions are made by qualified health professionals. The Delegate has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.4.2	Use of Practitioners for UM Decisions	Yes	The Delegate has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training, or professional experience in medical or clinical practice. 2. A current license to practice without restriction or an administrative license to review UM cases. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.4.3	Practitioner Review of Nonbehavioral Healthcare Denials	Yes	The Delegate uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity. 1. Medical reviewer signature or unique identifier (electronic or handwritten) must be noted within the file for all adverse decisions. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.4.4	Practitioner Review of Behavioral Healthcare Denials	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.4.5	Practitioner Review of Pharmacy Denials	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.4.6	Use of Board-Certified Consultants	Yes	The Delegate: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. Provides evidence that it uses board-certified consultants for medical necessity determinations. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Annual UM Program and Workplan (Initial) 2. Semi-Annual UM Work Plan (ICE) 3. Annual UM Evaluation (Previous Year)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 4.5: Timeliness of UM Decisions				
4.5.1	Notification of Nonbehavioral Decisions	Yes	The Delegate makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The Delegate adheres to the following time frames for notification of non- behavioral healthcare UM decisions: 1. For urgent concurrent decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 2. For urgent preservice decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. Medicare (OC/OCC): For nonurgent preservice decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 14 calendar days of the request. 4. Medi-Cal: For nonurgent preservice decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within five (5) working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request. 5. For post-service decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. The Delegate shall further comply with all applicable Standards and Requirements for the time frames for notification for non-behavioral UM decisions, including CalOptima Policy GG.1508: Authorization and Processing of Referrals. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring. CalOptima's oversight may include, without limitations, reviews of a sample of Delegate's UM denials in order to ensure service levels, quality, and compliance with applicable standards and requirements.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	
4.5.2	Notification of Behavioral Healthcare Decisions	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.5.3	Notification of Pharmacy Decisions	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.5.4	UM Timeliness Report	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.5.5	Interim- Policies and Procedures	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.6: Clinical Information				
4.6.1	Relevant Information for Nonbehavioral Healthcare Decisions	Yes	The Delegate uses all information relevant to a member's care when it makes coverage decisions. There is documentation that the Delegate gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.6.2	Relevant Information for Behavioral Healthcare Decisions	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.6.3	Relevant Information for Pharmacy Decisions	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.7: Denial Notices				
4.7.1	Discussing a Denial with a Reviewer	Yes	The Delegate gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. The name and direct telephone number, if available, or general number and extension number of the physician issuing the denial must be provided to the requesting provider. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.2	Written Notification of Nonbehavioral Healthcare Denial	Yes	The Delegate's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request. In addition to the foregoing, the written notification to the provider must include the name and direct telephone number, if available, or general number and extension number of the decision maker.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			The Delegate shall further comply with all applicable Standards and Requirements for written notice of action applicable for Medi-Cal or an integrated denial notice applicable to Medicare (OC/OCC), including Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	
4.7.3	Nonbehavioral Healthcare Notice of Appeal Rights/Process	Yes	The Delegate's written non-behavioral healthcare denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. a. The time frame for filling an expedited appeal. b. The Delegate's time frame for deciding the expedited appeal. c. The procedure for filling an expedited appeal, including where to direct the appeal and information to include in the appeal. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files 3. NOMNC Files (OneCare & OneCare Connect) 4. Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.7.4	Discussing a Behavioral Healthcare Denial with a Reviewer	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.7.5	Written Notification of Behavioral Healthcare Denials	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.7.6	Behavioral Healthcare Notice of Appeal Rights/Process	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.7.7	Discussing a Pharmacy Denial with a Reviewer	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.7.8	Written Notification of Pharmacy Denials	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.7.9	Pharmacy Notice of Appeal Rights/Process	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.8: Policies for Appeals				
4.8.1	Member Internal Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.9: Appropriate Handling of Appeals				
4.9.1	Member Preservice and Post Service Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.9.2	Timeliness of the Member Appeal Process	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.9.3	Appeal Reviewers	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.9.4	Notification of Appeal Decision/Rights	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.9.5	Final Internal and External Appeal Files	No	For Medi-Cal or OC/OCC, this function or activity is not applicable.	For Medi-Cal or OC/OCC, this function or activity is not applicable.
4.9.6	Appeals Overturned by the IRO	No	For Medi-Cal or OC/OCC, this function or activity is not applicable.	For Medi-Cal or OC/OCC, this function or activity is not applicable.
4.9.7	Provider Level 1 UM Appeals	Yes	Level 1 UM Appeals involve disputes related to utilization management decisions by the Delegate, including adverse benefit determinations based on medical necessity. Provider Level 1 UM Appeals only apply to post service appeals. Member preservice, expedited, and post service appeals are addressed in Sections 4.9.1. and 4.9.2. The Delegate shall process and resolve Provider Level 1 UM Appeals within contractual and regulatory timeframes as established by CalOptima and in accordance with applicable Standards and Requirements, including CalOptima Policies. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. UM Retrospective Appeal Universe	CalOptima conducts oversight assessments of delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
4.9.8	Provider Level 2 UM Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.10: Evaluation of New Technology				
4.10.1	Written Process	No	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
4.10.2	Description of the Evaluation Process	No	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.11: Procedures for Pharmaceutical Management				
4.11.1	Pharmaceutical Management Procedures	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.11.2	Pharmaceutical Restrictions/ Preferences	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.11.3	Pharmaceutical Patient Safety Issues	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.11.4	Reviewing and Updating Procedures	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.11.5	Considering Exceptions	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.12: UM System Controls				
4.12.1	UM Denial System Controls	Yes	The Delegate has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Specify system security controls in place to protect data from unauthorized modification.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and/or ongoing Monitoring, as appropriate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			a. Limiting physical access to the system. b. Preventing unauthorized access and changes to system data. c. Password-protecting electronic systems, including requirements to: use strong passwords, avoid writing down passwords, use different passwords for different accounts, and change passwords when requested by staff or if passwords are compromised. d. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to: change passwords when appropriate and disable or remove passwords of employees who leave the organization. 7. Specify how the Delegate audits the processes and procedures in factors 1-6. Delegate shall submit requisite documentation for Annual Audit and the following report(s) pursuant to the CalOptima Reporting Policy: 1. Utilization Management (UM) XML Universe 2. UM Universe Case Files	
4.12.2	UM Appeal System Controls	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 4.13: Delegation of UM				
4.13.1	Delegation Agreements	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.3	Review of the UM Program	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
4.13.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 4.14: Second Opinion				
4.14.1	Second Opinion	Yes	The Delegate provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. 1. If the Delegate is unable to provide a necessary and covered service to a member in-network, the organization must adequately and timely cover these services of out of network, for as long as the Delegate is unable to provide the services. 2. If the Delegate approves a member to out of network because it is unable to provide a necessary and covered service in-network, the Delegate coordinates payment with out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network. If the member is requesting a second opinion from the member's primary care practitioner/physician (PCP), the member may receive the second opinion from an appropriately qualified health care professional of the member's choice from within the Delegate's provider network. If the member is requesting a second opinion from a specialist, the member may receive the second opinion from any specialist of the same or equivalent specialty of the member's choice within the Delegate's provider network. 1. If a specialist is not available within the Delegate's provider network, a Delegate shall arrange for the second opinion from a non-contracted provider and shall incur the cost or negotiate the fee arrangement of that second opinion. The Delegate shall authorize a request for a third opinion if the recommendations of the first and second practitioner differ regarding the need for a medical procedure and a member, member's authorized representative, physician, or provider requests such third opinion. The Delegate shall further comply with all applicable Standards and Requirements, including CalOptima Policy GG.1538: Referral of Second Opinion. Delegate shall submit requisite documentation for Annual Audit pursuant to CalOptima Reporting Policy.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 5: Credentialing and Recredentialing (CR)				
Section 5.1: Credentialing Policies				
5.1.1	Practitioner Credentialing Guidelines	Yes	Delegate shall document its process for credentialing and re-credentialing licensed independent practitioners it employs or with whom it contracts and who fall within its scope of authority and action. The Delegate's credentialing policies specify: 1. The types of practitioners to credential and recredential. 2. The verification sources used. 3. The criteria for credentialing and recredentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 7. The process for notifying practitioners if information obtained during the credentialing process varies substantially from the information they provided to the Delegate. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. 9. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. 12. The process for ensuring the following are reviewed during initial and recredentialing process: a. Quality improvement activities and member complaints. b. Review of CMS Opt-out, CMS Exclusions/Sanctions, and CMS Preclusion. c. Practitioners Medi-Cal enrollment. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
5.1.2	Practitioner Rights	Yes	The Delegate notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. 3. Receive the status of their credentialing or recredentialing application, upon request. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.1.3	Credentialing Systems Controls	Yes	The Delegate's credentialing process describes: 1. How primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification 3. Staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. a. Limiting physical access to credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. b. Preventing unauthorized access, changes to and release of credentialing information. c. Password-protecting electronic systems, including user requirements to: use strong passwords, avoid writing down passwords, use different passwords for different accounts, and change passwords when requested by staff or if passwords are compromised. d. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to: change passwords when appropriate, and disable or remove passwords if employees leave the organization. 5. How the organization audits the processes and procedures in factors 1-4. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 5.2: Credentialing Committee				
5.2.1	Credentialing Committee	Yes	The Delegate obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions. The Delegate's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. 2. Reviews credentials for practitioners who do not meet established thresholds. 3. Ensures that files that meet established criteria are reviewed and approved by a Medical Director or designated physician. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.3: Credentialing Verification				
5.3.1	Verification of Credentials	Yes	The Delegate conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. The Delegate verifies credentialing information through primary sources, unless otherwise indicated. The Delegate verifies that the following are within the prescribed time limits: 1. A current and valid license to practice. 2. A valid DEA or CDS certificate, if applicable. 3. Education and training, as specified in the NCQA Standards and Guidelines 4. Board certification status, if applicable. 5. Work history. 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
5.3.2	Sanction Information	Yes	The Delegate verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure or limitations on scope of practice. 2. Medicare and Medicaid sanctions. 3. Medi-Cal Suspended & Ineligible 4. Medicare Opt-Out 5. Excluded Parties List System/System for Award Management (EPLS/SAM) 6. CMS Preclusions Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.3.3	Credentialing Application	Yes	The Delegate performs primary source verification and credentialing and re-credentialing decision-making, which includes using an application and signed attestation. The Delegate ensures applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Hospital admitting privileges or coverage 7. Current and signed attestation confirming the correctness and completeness of the application. 8. A current facility site review is included for PCP in the credentialing file. 9. Process and procedure for identifying HIV/AIDS Specialist Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.4: Recredentialing Cycle Length				
5.4.1	Recredentialing Cycle Length	Yes	The length of the recredentialing cycle is within the required 36-month time frame. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 5.5: Ongoing Monitoring and Interventions				
5.5.1	Ongoing Monitoring and Interventions	Yes	Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The Delegate implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions (i.e., Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, Excluded Parties List System/System for Award Management (EPLS/SAM), CMS Preclusion). 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.6: Notification to Authorities and Practitioner Appeal Rights				
5.6.1	Actions Against Practitioners	Yes	The Delegate uses objective evidence and patient care considerations to decide on altering a practitioner's relationship with Delegate if the practitioner does not meet Delegate's quality standards. The Delegate has policies and procedures for: 1. The range of actions available to the Delegate. 2. Making the appeal process known to practitioners. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
Section 5.7: Assessment of Organizational Providers				
5.7.1	Review and Approval of Provider	Yes	The Delegate assesses and approves, initially and in an ongoing manner, provider organizations. The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. Ensures that the provider is Medi-Cal enrolled. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	
5.7.2	Medical Providers	Yes	The Delegate includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.7.3	Behavioral Healthcare Providers	No	For Medi-Cal, this function or activity is not applicable because behavioral health facilities are carved out to the Orange County Health Care Agency (HCA). For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this standard is not applicable for because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
5.7.4	Assessing Medical Providers	Yes	The Delegate assesses contracted medical health care providers against the requirements and within the timeframe in Section 5.7.1. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Credentialing Monthly Universe 2. Credentialing Universe Monthly Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
5.7.5	Assessing Behavioral Healthcare Providers	No	For Medi-Cal, this function or activity is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.

Section:	Title	Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 5.8: Delegation of CR				
5.8.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
5.8.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
5.8.3	Review of the Delegate's Credentialing Activities	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
5.8.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section 6: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 6: Member Experience (ME)				
Section 6.1: Statement of Members' Rights and Responsibilities				
6.1.1	Rights and Responsibilities Statement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.1.2	Distribution of Rights Statement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.2: Subscriber Information				
6.2.1	Subscriber Information	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.2.2	Interpreter Services	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.3: Marketing Information				
6.3.1	Materials and Presentations	No	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
6.3.2	Communicating with Prospective Members	No	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
6.3.3	Assessing Member Understanding	No	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.	For Medi-Cal, this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.

Section 6: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 6.4: Functionality of Claims Processing				
6.4.1	Functionality: Website	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.4.2	Functionality: Telephone Requests	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.5: Pharmacy Benefit Information				
6.5.1	Pharmacy Benefit Information: Website	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.5.2	Pharmacy Benefits Information: Telephone	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.5.3	QI Process on Accuracy of Information	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.5.4	Pharmacy Benefit Updates	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.6: Personalized Information on Health Plan Services				
6.6.1	Functionality: Website	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.6.2	Functionality: Telephone	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.6.3	Quality and Accuracy of Information	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.6.4	E-Mail Response Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section 6: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Section 6.7: Member Experience				
6.7.1	Policies and Procedures for Complaints	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.2	Policies and Procedures for Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.3	Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.4	Nonbehavioral Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.5	Annual Assessment of Behavioral Healthcare and Services	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.7.6	Behavioral Healthcare Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
Section 6.8: Delegation of ME				
6.8.1	Delegation Agreement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.8.2	Pre-delegation Evaluation	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
6.8.3	Review of Performance	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

Section 6: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
6.8.4	Opportunities for Improvement	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 7: Claims				
Section 7.1: Claims				
7.1.1	Claims Processing and Exclusion and Preclusion Monitoring	Yes	1. The Delegate shall identify and acknowledge electronic claims within two (2) working days of the date of receipt of the claim. 2. The Delegate shall identify and acknowledge paper claims within fifteen (15) working days of the date of receipt of the claim. 3. The Delegate shall not reimburse or make payment for services provided under the medical direction of a provider or entity that is verified to be suspended, debarred, precluded, or excluded from participation in federal or state health care programs. 4. Delegate shall verify provider or entity's participation status as required by CalOptima Policy HH.2021: Exclusion and Preclusion Monitoring. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report 4. Preclusion List Report for Member Notifications Only	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.2	Claims Forwarding	Yes	The Delegate shall forward all claims received incorrectly to the correct entity within ten (10) working days of the receipt of the claim. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.3	Interest Payment of Emergency Services Claims	Yes	For late payment on a complete claim for emergency services, the Delegate shall automatically include the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof, on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
7.1.4	Timeliness of Claims Processing	Yes	Medi-Cal 1. The Delegate shall process and adjudicate ninety percent (90%) of all non-contracted and contracted clean claims for covered services provided to members within thirty (30) calendar days after Delegate's receipt of such claims (from the earliest date stamp through the date the payment check or notice was mailed) 2. The Delegate shall process and adjudicate ninety-nine percent (99%) of all clean claims for covered services provided to members within ninety (90) calendar days after Delegate's receipt of such claims. Medicare (OC/OCC) 1. The Delegate shall process and adjudicate ninety-five percent (95%) of all non-contracted and contracted clean claims for covered services provided to a member within thirty (30) calendar days after Delegate's receipt of such claims. 2. All other claims from non-contracted providers shall be paid or denied within sixty (60) calendar days from the date of request. 3. The Delegate shall process and adjudicate ninety-nine percent (99%) of all contracted clean claims for covered services provided to a member within ninety (90) calendar days after Delegate's receipt of such claims. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report 4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.
7.1.5	Claims Processing and Coordination of Benefits	Yes	1. The Delegate shall have procedures in place to identify payers that are primary and secondary to determine amounts payable, and coordinate benefits for members with Other Health Coverage (OHC), in accordance with the Medicare and Medi-Cal crossover claims guidelines. 2. The Delegate shall identify and report to CalOptima any member reports of other employer health coverage or other private or public health insurance. 3. Delegate shall identify and report to CalOptima any Explanation of Payment (EOP) or Explanation of Medical Benefits (EOMB) received with other coverage payment. 4. If the member has OHC, the Delegate shall consider the OHC plan as the member's primary health plan. 5. The Delegate shall remain the secondary health plan and payer of last sort.	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
			6. If the member has both Medicare (OC/OCC) and OHC plan, both Medicare (OC/OCC) and OHC plan shall pay claims for services prior to the payment consideration of the Delegate. 7. The Delegate shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and B, as required by current regulations. 8. The Delegate shall adjudicate the billed amount based upon the maximum allowed amount, billed charge, the deductible, or co-payment, whichever is less. 9. The Delegate shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations. Delegate shall submit the following report(s) pursuant to CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. Claims TPL (OneCare Connect) 5. DHCS Post-Payment Recovery Report (Medi-Cal Only) *6.* Claims Timeliness Report	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions – Level 1	Yes	The Delegate shall accurately conduct claims processing. The Delegate shall process and resolve Level 1 provider disputes related to claims payment decisions within contractual and regulatory timeframes as established by CalOptima and in accordance with applicable Standards and Requirements, including CalOptima Policies. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. Claims TPL (OneCare Connect) 5. DHCS Post-Payment Recovery Report (Medi-Cal Only) 6. Claims Timeliness Report 7. Provider Dispute Resolution (PDR) XML Universe 8. PDR Universe Case Files	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions – Level 2	No	This function or activity is retained by CalOptima and is not delegated to the Delegate.	This function or activity is retained by CalOptima and is not delegated to the Delegate.
7.1.8	Third Party Liability (TPL)	Yes	Medi-Cal and OCC 1. Delegate shall make no claim for recovery of the value of covered services rendered to a member in an instance, or case, where an action by a member involving casualty insurance, tort, or Workers' Compensation liability of a third party could result in a member's recovery of funds to which the Department of Health Care Services (DHCS) has lien rights. a. The Delegate shall notify CalOptima within five (5) calendar days of becoming aware of an instance, or case, of potential TPL relative to covered services provided to a member. 2. The Delegate shall respond within twenty (20) calendar days of a request from CalOptima and/or DHCS for a Medi-Cal member's paid claims data and include an itemized list of all services provided to the member from the date of injury forward. The Delegate shall further comply with all applicable Standards and Requirements, including CalOptima Policy FF.2007: Reporting of Potential Third Party Liability. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Third Party Liability (TPL) 4. Claims TPL (OneCare Connect) 5. DHCS Post-Payment Recovery Report (Medi-Cal Only) 6. Claims Timeliness Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 8: Provider Complaint				
Section 8.1: Provider Complaint Processing				
8.1.1	Provider Complaint Processing	No	This function or activity related to Provider Complaint Processing is retained by CalOptima and is not delegated to the Delegate. Provider Complaint Processing involves disputes related to decisions or actions taken by the Delegate, including disputes about the CalOptima Program, but excluding utilization management disputes and claims payment disputes which are separately addressed in Sections 4.9.7 and 7.1.6 respectively.	This function or activity is retained by CalOptima and is not delegated to the Delegate.

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Section: Title		Delegated Yes/No	Delegate Responsibilities	CalOptima Responsibilities
Article 9: Medicaid				
Sections 9.1 – 9.3: Intentionally Left Blank				
Section 9.4: Care Coordination				
9.4.1	Coordinating Health Care Services for Members	Yes	The Delegate's care coordination process includes provisions for all members, including: 1. Having a person or entity formally assigned to coordinate health care services provided to members. 2. Providing the contact information of the individuals coordinating healthcare services to members. Delegate shall submit the following report(s) pursuant to the CalOptima Reporting Policy: 1. Health Homes Program (HHP) Enrollment and Disenrollment 2. HHP Services 3. Implementation Audit (OneCare) 4. Implementation Audit (OneCare Connect) 5. ICT Bundle (OneCare) 6. Individual Care Plan/Health Action Plan (ICP/HAP) bundle 7. Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect) 8. MOC Tracking Log (OneCare) 9. MOC Tracking Log (OneCare Connect) 10. MOC WCM Tracking Log (Medi-Cal) 11. Model of Care (MOC) SPD Tracking Log (Medi-Cal) 12. Network Staff Legend File 13. DHCS WCM Report	CalOptima conducts oversight assessments of the delegated activities, including Audits annually or as often as necessary and ongoing Monitoring.

MEDI-CAL

PHYSICIAN – SHARED RISK

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

INSERT PROVIDER NAME

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

PHYSICIAN
(Shared Risk)

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered by and between Orange County Health Authority, a public agency, dba CalOptima, ("CalOptima"), and _____, a _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Physician is a California professional medical corporation, which employs or otherwise contracts with physicians who are physicians licensed to practice medicine in the State of California.

D. Physician desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. CalOptima and Physician desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the Physician and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 “Adult Expansion Member” means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 “Advance Directive” means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 “Aid Code” means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 “American Indian” means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 “American Indian Health Care Provider” means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 “American Indian Health Service Programs” means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.

1.8 “Approved Drug List” means CalOptima’s continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 “California Children’s Services (CCS)” means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 “California Children’s Services (CCS) Eligible Condition(s)”, means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 “California Children’s Services (CCS) Program” means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy

services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or Physician group.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the Physician by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or Physician group or from one Health Network or Physician group to another Health Network or Physician group; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal. .

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in a Health Network or Physician group.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Physician. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on Physician, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22, of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network or Physician group regardless of Health Network or Physician group reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 “Health Education” means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 “Health Maintenance Organization” or “HMO” means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) (“Knox-Keene Act”).

1.45 “Health Network” means a physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 “Healthcare Effectiveness Data and Information Set” or “HEDIS” means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 “HHS” means the United States Department of Health and Human Services.

1.48 “Hospital” means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act) and having a Hospital Services Contract with CalOptima.

1.49 “Incontinence Supplies” means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 “Joint Commission” means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 “Long Term Care Facility” means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 “Management Services Organization” or “MSO” means any organization, firm, company or entity providing Administrative Services on behalf of Physician which impact CalOptima Members.

1.53 “Medi-Cal” is the name for the Medicaid program in the State of California, and “Medicaid” is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 “Medi-Cal Fee Schedule” means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within Physician's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and assigned to Physician.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks, Physician groups and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled with Physician.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Physician or Hospital to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Physician. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

1.77 "Physician Incentive Plan" means any compensation arrangement between Physician and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.80 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.81 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.82 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.83 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Physician, which limits the amount of risk or liability for the cost of providing Covered Services.

1.84 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

1.85 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing

1.86 "Shared Risk Pool" means the risk sharing program, described in Attachment E hereto, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician.

1.87 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.88 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.89 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.90 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.91 "Specialty Mental Health Services" means:

1.91.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.91.2 Psychiatric inpatient hospital services;

1.91.3 Targeted Care Management services;

1.91.4 Psychiatrist services;

1.91.5 Psychologist services; and

1.91.6 EPSDT supplemental specialty mental health services.

1.92 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.93 "State" means the State of California.

1.94 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.95 "Subcontract" means an agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.96 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.97 "Sub-delegation" means the process by which Physician expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Physician in order to meet its obligations under, and the intent of this Contract.

1.98 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.99 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.100 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of Physician – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Physician must establish and maintain, throughout the term of this Contract, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS---

2.3.1 Professional/Medical Malpractice:

Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician :
$1,000,000 per incident/$3,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:

Physician and each Participating Provider shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:

Physician and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily Injury by Accident - each accident

$1,000,000 Bodily Injury by Disease - policy limit

$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:

Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:

$10,000,000 each claim/$10,000,000 aggregate

2.3.5 Insurer Ratings ---
Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured:

Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change:
The Shared Risk Group shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- Physician shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHYSICIAN FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- Physician shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, Physician shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 Not Applicable to this Contract.

2.7 PHYSICIAN PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - Physician and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

2.7.2 Claims Turnaround Time - Physician shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician, unless the claim or portion thereof is reasonably contested by Physician, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, Physician shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - Physician shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - Physician shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of Physician

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If Physician does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that Physician fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Physician for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that Physician fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from Physician for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Physician Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Physician, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 Physician shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71,

1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 Physician shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Physician, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 Physician's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 Physician shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. Physician will receive misdirected claims per CalOptima Policy.

2.7.9.2 Physician shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHC Payments – If FQHC, Physician shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - Physician shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Physician shall reimburse the American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.7.13 Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information.

2.7.15 HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician.

2.7.16 Information Disclosures To Participating Providers Physician shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments –

2.7.17.1 Physician shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than one hundred thirty-three percent (133%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in

the CalOptima Whole Child Model Program, Physician shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by Physician and the physician and surgeon.

2.7.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Physician shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Physician shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. Physician shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Physician shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Physician does not have sufficient information to determine whether or not

OHC is the result of child support enforcement case, then Physician shall follow the procedure above for cost avoidance. If Physician does not reimburse a Provider on a Fee-for-Service basis, then Physician shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Physician shall have written policies implementing these requirements.

2.9.4 Physician shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Physician shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Physician shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 Physician shall demonstrate to CalOptima that where Physician does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Physician projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- Physician shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%) when combined with the revenues and expenses of the Shared Risk Pool, which are identified in Attachment E.

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- Physician shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. Physician shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.12 COOPERATION WITH DMHC --- Physician shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to Physician, in accordance with Section 1300.75.4.7 of Title 28 of the California

Code of Regulations. Physician shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of Physician - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY

3.2.1 Physician and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Physician and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Physician and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 Physician and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Physician and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Physician and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Physician and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Physician and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Physician and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Physician and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Physician and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Physician and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Physician and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Physician and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Physician shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Physician shall display the CalOptima logo on all Physicians' written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. Physician shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 MEMBER INQUIRIES AND CALLS --- Physician shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician's call center shall meet requirements established by CalOptima Policies. Physician shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Physician will be able to supply call center reports as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Physician shall ensure that all written Member information provided by Physician to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion

appropriate for the format being requested. Physician shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Physician. Physician shall implement and comply with CalOptima Policies relating to Member grievances. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Physician. Physician shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES.

Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Physician may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of Physician but shall not absolve Physician of oversight responsibilities. All sub-delegation must be approved by CalOptima. Physician shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Physician's sub-delegation to another entity does not alter Physician's ultimate obligation and responsibilities set forth in this Contract. Physician may give a sub-delegate the authority to act on behalf of Physician; but Physician retains oversight and accountability for the sub-delegated function. Accountability means that Physician cannot abdicate responsibility for the function being performed according to the requirements of this Contract, Physician's standards and those established by this Contract and CalOptima Policies. Physician is accountable for all functions performed in its purview whether by Physician, by any sub-delegate or by any sub-sub-delegate. If Physician chooses to sub-delegate a function, Physician must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, Physician shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Physician and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Physician evaluates the sub-delegate entity's performance; and

3.8.1.5 The Physician's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Physician's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Physician's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Physician's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Physician's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Physician shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Physician shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Physician's Members, including those receiving services from a sub-delegate of Physician.

3.8.6 Physician shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Physician shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Physician in this Contract and in CalOptima Policies. Physician may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network or Physician group, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Physician to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Physician shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, Physician shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.17 to 3.22 of this Contract;.

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10 and 7.11 of this Contract, and to gather, preserve, and provide any records in the

Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Physician, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on Physician;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services, and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, as set forth in Attachment D of this Contract, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Physician cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Physician and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract.

3.9.15 In the event that Physician implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Physician.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or Physician determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Physician to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- Physician shall comply with the following organization and operations structure requirements:

3.10.1 Single Board of Directors and management team.

3.10.2 Medical Director/CMO providing full time coverage. Duties shall include:

- Ensuring that medical decision are:
  - Rendered by qualified medical personnel
  - Are not unduly influenced by fiscal or administrative management considerations.
- Ensuring that the medical care provided meets the standards for acceptable medical care.
- Ensuring that medical protocols and Standards of Conduct for medical personnel are followed.
- Developing and implementing medical policy.
- Resolve grievances related to medical quality of care.
- Have a role in the implementation of Quality Improvement activities.
- Actively participate in the functioning of the grievance procedures.

- Actively participate in Quality activities including Credentialing and Peer Review.

- Acts as liaison and participates with CalOptima in any activities related to Medical Director/CMO duties.

PHYSICIAN shall report to CalOptima any changes in the status of its Medical Director within ten (10) calendar days.

3.10.3 No employee of Physician, including but not limited to Medical Director(s) and/or the Chief Medical Officer, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.10.4 Single Credentialing Committee and credentialing policies, procedures and standards.

3.10.5 Single and unified health care delivery system including but not limited to:

3.10.5.1 Participating Providers must be accessible to all members enrolled with Physician.

3.10.5.2 Members can select any contracted PCP with an open panel.

3.10.5.3 A PCP can refer members to any contracted specialist.

3.10.5.4 Physician must report to CalOptima all required data for the total enrollment of the Physician and the total provider network regardless of sub-delegation or other contractual relationships including but not limited to; complaints, encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

3.10.5.5 Centralized call center receiving all member and provider calls.

3.10.5.6 Single access number to call center.

3.10.5.7 Standard member communication for all members.

3.10.6 Other organization and operations structure requirements as may be established and modified from time to time by CalOptima.

3.11 ENROLLMENT --- Physician shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to Physician.

3.12 PCP ASSIGNMENT --- Physician shall assign Members who have been automatically assigned to Physician by CalOptima to a PCP within seven (7) days of the Member's assignment to Physician.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE ---Physician shall mail to a Member or Member's head of household a notice of enrollment and a Physician Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with Physician. All member handbooks and supplements prepared by Physician shall be submitted to CalOptima for approval prior to printing. Physician shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should Physician choose to utilize the CalOptima Member handbook, Physician-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all Physicians' CalOptima Members. CalOptima shall provide Physician with a template for the supplement to the CalOptima member handbook.

3.13.2 If Physician chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, Physician's Member handbook shall contain all information included in the CalOptima Member handbook and Physician-specific information on each topic as defined by CalOptima Policies.

3.13.3 Physician shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. Physician shall also provide one (1) copy of its enrollment information including its Physician Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- Physician may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from Physician. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Physician shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Physician shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

3.17.1 Physician and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Physician shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Physician, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Physician, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Physician, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Physician and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Physician or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Physician shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Physician or Subcontractor, Physician shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State’s Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima’s Regulators; (b) at all

reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Physician shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by Physician and Subcontractors pertaining to these services at any time,, pursuant to 42 CFR section 438.3(h). Records and documents include but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Physician shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Physician's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Physician's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Physician's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Physician, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Physician. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Physician will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS. Throughout the duration of the Contract and the retention period specified in Section 3.18, Physician and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Physician's provision of and reimbursement for activities contemplated under the Contract, and to Physician's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign Physician's statement of confidentiality prior to being admitted access to Physician's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Physician at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program; seek recovery of payments made to the Physician; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Physician shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time may be of the essence in responding to such request. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Physician or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Physician further agrees to timely gather, preserve, and provide to DHCS any records in the Physician's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Physician and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a

Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, Physician shall keep CalOptima informed as to the names of the officers and owners of Physician holding more than five percent (5%) of the stock issued by Physician, and major creditors holding more than five percent (5%) of the debt of Physician and shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or Physician's employees, within two (2) working days of the date when Physician first becomes aware of or is on notice of such activity.

3.24.1 Physician shall notify CalOptima, and CalOptima shall notify DHCS prior to Physician conducting any investigations. Physician shall conduct an investigation after notification has been given.

3.24.2 Physician shall establish, for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Physician shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Physician shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects

the Physician's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 PHYSICIAN COMPLIANCE PROGRAM --- Physician shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Physician annually to ensure that it remains effective. Physician shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- Physician and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Physician's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician and Physician shall make them available to Physician's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Physician agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Physician acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Physician shall have policies and procedures to verify the Participation Status of Physician's Agents. Physician shall refer to the Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems

(EPLS) in the SAM System (https://www.sam.gov). In addition, Physician warrants and agrees as follows:

3.31.1 Physician and Physician's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Physician shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Physician or Physician's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Physician shall take immediate action to remove any Physician Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Physician shall include the obligations of this Section in its Subcontracts.

3.31.5 CalOptima and Physician, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Physician and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Physician and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Physician shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not

be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Physician shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Physician shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Physician shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Physician shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Physician shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Physician shall provide translation of written member informing materials in the Threshold and Concentration Languages. Physician shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Physician shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Physician shall be

responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Physician shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Physician shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Physician shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Physician shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Physician shall make Member Rights available to Member..

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Physician shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 Physician and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Physician shall comply with HIPAA requirements as currently established in CalOptima Policies. Physician shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Physician HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Physician and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Physician, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Physician's obligations under this Contract. Physician and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-

mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Physician from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Physician is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Physician by DHCS for this purpose.

3.39 REINSURANCE -- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Physician may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E of this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Physician shall have a process for claims management and administration. Physician shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Physician shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Physician shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Physician shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Physician shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Physician shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Physician shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 PHYSICIAN SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Physician shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. Physician shall ensure that all Subcontracts are in writing and require that the Physician and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the final date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Physician understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Physician under this Contract. In instances where DHCS or CalOptima determines that the Physician or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the Physician, (b) require the Physician to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify

other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Physician shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Physician or the oversight of those obligations.

ARTICLE 4
Obligations of Physician – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Physician shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Physician, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Physician shall provide Covered Services to Members and Physician agrees as follows:

4.1.1 Physician shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of Physician as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Physician's network is unable to provide necessary medical services covered under this Contract to a particular Member, Physician must adequately and timely cover these services out of network for the Member, for as long as Physician is unable to provide them. Physician shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Physician shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician thirty (30) calendar days' notice of any such change.

CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating with Physician as to the Medical Necessity of the service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 Physician shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Physician denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Physician acknowledges that disputes between the respective Physician and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Physician may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Physician shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or Physician, CalOptima's or the Physician's insolvency, or breach of this Contract by the Physician or CalOptima, shall Physician or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit Physician or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. Physician or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of

this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Physician and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Physician's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Physician and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 That, in the event of a violation of this Section by Physician or Subcontractor, including, but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Physician or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Physician shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Physician reasonably determines that Emergency Services were never performed.

4.2.2 Not Applicable to this Contract.

4.2.3 Physician shall reimburse those physicians providing services in an Emergency Department with whom Physician has a contract according to the terms of that contract. Physician shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. Physician shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 Physician shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Physician shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, Physician shall not deny payment for treatment obtained when Physician or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 Physician shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between Physician or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Physician may establish relationships with treating facility whereby the Physician may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on Physician.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Physician is financially responsible for post-stabilization services obtained within or outside Physician's network that are pre-approved by a plan provider or other entity representative. Physician is financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other Physician representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to Physician for pre-approval of further post-stabilization care services.

4.2.8.1 Physician is also financially responsible for post-stabilization care services obtained within or outside Physician's network that

are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Physician does not respond to a request for pre-approval within 30 minutes; Physician cannot be contacted; or Physician's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Physician must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 Physician's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Not Applicable to this Contract.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, Physician is financially responsible for payment for post-stabilization services following an emergency admission. Physician shall reimburse those physicians providing post-stabilization services with whom Physician has a contract according to the terms of that contract. Physician shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- Physician shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Physician is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Physician shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Physician to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Physician from financial responsibility for such services.

4.4.2 Physician shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 Physician shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Physician shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Physician shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 Physician shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Physician shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Physician shall arrange for the timely referral and coordination of Covered Services to which Physician or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES. Physician shall ensure the provision of SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment

when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician without first requesting a referral from a network Primary Care Physician. Physician shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- Physician acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify Physician of the date upon which Physician will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time Physician shall commence all CalOptima WCM obligations.

5
Obligations of Physician – Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Physician shall ensure that a physician Participating Provider or physician employed by Physician is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, Physician shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies

5.2 URGENT CARE SERVICES --- Physician shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Physician shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as

appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Physician shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- Physician shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 Not Applicable to this Contract.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services – Physician shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. Physician shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – Physician shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. Physician shall arrange for the provision of specialty services from specialists outside the network if unavailable within Physician's network, when determined medically necessary.

5.6.3 Preventive Covered Services – Physician shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services – Physician shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in

accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. Physician shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement – Physician shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization – within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to members who are receiving treatment for a chronic or ongoing medical condition or LTSS.

5.7 OFFICE WAITING TIMES --- Physician shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject Physician to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- Physician shall provide a decision on authorization requests for those Covered Services that are not Urgent

Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Physician's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- Physician shall give Members thirty (30) calendar days' notice if their PCP withdraws from Physician. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- Physician shall offer each Member the opportunity to choose a PCP affiliated with the Physician. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment with Physician. Physician shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Physician shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended,

excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, Physician shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-Physician Medical Practitioners are included in Physician's Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - Physician shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- Physician shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as

required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles from Member's place of residence.

5.16 PHYSICAL ACCESS --- Physician's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- Physician shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.

5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members

ARTICLE 6
Obligations of Physician – Clinical Quality

6.1 LICENSURE --- Physician shall ensure that every physician providing Covered Services and employed or engaged by Physician or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Physician shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Physician shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of the Physician or a multi-disciplinary QI Committee designated by the Board of Directors of Physician shall oversee the QI Program conducted by Physician. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from Physician. The QI Committee shall meet at least on a quarterly basis. Physician shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to Physician's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 Physician's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 Physician shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or Physician; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 Physician shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the Physician's QI Program shall be established by the Physician's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify Physician of any additional changes in QI standards and requirements that shall be incorporated in Physician's QI Program. Physician shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 Physician shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, Physician shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 Physician shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 Physician shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Physician shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Physician's Case Management Services program to determine compliance with Case Management Services standards. Physician shall furnish Case Management Services records and information to CalOptima upon

request.

6.5.4 Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Physician shall assure that Physician possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF PHYSICIAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Physician shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Physician shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Physician shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Physician shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or Physician decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician, but the rest of the group continues its contract with Physician, then Physician shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2^{nd}) or third (3^{rd}) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019 or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9

and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, Physician shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by Physician's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Physician shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- Physician shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. Physician shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. Physician's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. Physician must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, Physician may use an out-of-state Provider, in accordance with APL 17-019, if an in-state

CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated Physician shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated Physician shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Physician shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Physician shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 Physician shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, Physician shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be

followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 Physician shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by Physician, Physician remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code, Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Physician must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, Physician may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Physician must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Physician's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Physician and the CCS Provider.

6.7.5.2.3 Physician confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or the Provider of Specialized Durable Medical Equipment makes treatment information available to Physician, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, Physician and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, Physician shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Physician shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. Physician shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care

Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 Physician shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, Physician shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 Physician shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, Physician shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, Physician shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition Physician for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if Physician denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 Physician must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- Physician acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician. Physician shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 Physician shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 Physician shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. Physician shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 Physician shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 Not Applicable to this Contract.

6.9 BOARD CERTIFICATION --- --- Physician shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 Physician shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 Physician acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with Physician to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Physician shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Physician shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- Physician shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Physician shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Physician shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 Physician shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 Physician shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 Physician shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 Physician shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 Physician shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 Physician shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Physician shall develop referral and prior authorization policies and procedures to implement the above requirements. Physician shall submit these policies to CalOptima for review and approval;

6.11.8.9 Physician shall provide outpatient mental health services within the PCP's scope of practice. Physician shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. Physician shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. Physician shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.;

6.11.8.11 For Outpatient Mental Health Services , Physician shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, Physician shall refer Members to

CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use it as the Physician is able for the purpose of Member care coordination.

6.12 VACCINES --- Physicians shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with Physician's immunization policy. CalOptima shall not reimburse Physician for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program.

Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 Physician may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- Physician agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF PHYSICIAN FOR SPD --- Physician shall provide the following for SPD Members:

6.15.1 Physician shall participate in the Community Liaison Program according to the guidelines and policies CalOptima promulgates to operate the program and as set forth in this Contract and CalOptima Policies;

6.15.2 Physician shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 Physician shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. Physician shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 Physician shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) Physician determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD

Member's need for the Medical Supplies will remain stable over the six (6) month period.

6.15.5 Physician or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. Physician shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, Physician shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the Physician;

6.15.6 Physician shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. Physician shall provide to all SPD Members upon enrollment with Physician and at any time thereafter, upon the SPD Member's request, a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment with Physician of an SPD Member, Physician shall complete a plan of care pursuant to CalOptima Policies. Physician shall update this plan as appropriate and/or annually. Physician shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies enrolled with Physician, Physician shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 Physician shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 Physician shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If Physician's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, Physician must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. Physician acknowledges that out-of-network providers must coordinate with Physician with respect to payment, and Physician shall ensure that such out-of-network providers understand this requirement. Physician must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. Physician shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, Physician shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept Physician or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, Physician shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions:

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members. The Profile shall include the compliance parameters required to receive PCC supplemental capitation.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.15 Physician shall be eligible to receive the supplemental PCC capitation as defined in Attachment E if Physician remains in good standing with CalOptima which shall include but not limited to the following:

6.15.15.1 No sanctions in place for the Medi-Cal program;
6.15.15.2 Resolution satisfactory to CalOptima of all identified Medi-Cal Program compliance deficiencies from the preceding calendar quarter;
6.15.15.3 Execution of all previous amendments; and
6.15.15.4 Other requirements contained in CalOptima Policy, as applicable.

6.15.16 During any period in which CalOptima provides funding for the PCC program, and written notice that the program is active, Physician shall provide PCC services in accordance with the following:

6.15.16.1 Physician shall employ PCCs and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. Physician shall staff one PCC per six hundred (600) CCS or SPD Members assigned to Physician. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. Physician shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.16.2 CalOptima shall provide Physician the Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to Physician thirty (30) days prior to the effective date of such change. If Physician is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30)-day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to Physician and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- Physician shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Physician shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- Physician shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- Physician shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Physician shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. The Physician shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- Physician shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Physician shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, Physician and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of Physician – Reporting

7.1 DATA REPORTING REQUIREMENTS --- Physician shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Physician shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- Physician shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Physician shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Physician shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Physician shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Physician shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Physician should CalOptima determine that Physician is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Physician agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician as related to Members. Physician shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If Physician is required to file monthly Financial Statements with the DMHC, Physician shall simultaneously file monthly Financial Statements with DHCS. Physician shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Physician shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Physician shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Physician's provider network.

7.6 PHYSICIAN ORGANIZATION PROFILE --- Physician shall report in compliance with CalOptima Policies, a profile of the Physician's organization, including, but not limited to, Physician's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Physician shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Physician, Physician shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Physician shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract.

7.8 DISCLOSURE --- Physician and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician's or Subcontractor's financial records related to Physician's capacity to bear the risk of potential financial losses, or the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Physician, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Physician shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – Physician shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Physician shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Physician to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Physician's letterhead signed by the Physician's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Physician – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Physician shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Physician at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Physician received Capitation Payment and termination occurred, Physician shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Physician shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Physician agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Physician.

8.3 TERMINATION PLANS --- Physician shall have a plan for the orderly termination of services under this Contract. Physician shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60

days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Physician acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Physician shall notify DHCS of amendments to, or termination of, this Contract . Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Physician acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Physician shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with Physician, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Physician on or about the fifteenth (15^{th}) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Physician.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Physician an amount equal to X percent (X%) of the monthly Capitation Payment (Withhold). CalOptima may adjust Physician's Capitation Payment on a quarterly basis should the Withhold fall below X percent (X%) of Physician's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Physician. If the State has provided CalOptima with advance notice of

adjustment, CalOptima shall provide notice thereof to Physician as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Physician shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- Physician has an obligation to report any overpayment identified by Physician, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Physician, or of receipt of notice of an overpayment identified by CalOptima. Physician acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician, CalOptima shall have the right to recover such amounts from Physician by recoupment or offset from current or future amounts due from CalOptima to Physician, after giving Physician notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Physician to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by Physician to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.
9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to Physician's capitation
9.4.6 Payments made by CalOptima that are the financial responsibility of Physician.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician paid by CalOptima against any funds owed to Physician by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Physician additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Physician any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Physician.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to Physician is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY---Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Physician shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician any material deficits.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Physician's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Physician accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Physician interpretation of MOUs entered into by CalOptima that are binding on Physician. Interpretation of MOUs will identify duties, obligation and responsibilities of Physician.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Physician acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Physician, information and data relating to the performance of Physician that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Physician, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Physician the financial risk assumed under the Contract by providing to Physician the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Physician, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Physician the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Physician sufficient details to allow Physician to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Physician, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF PHYSICIAN TERMINATION PLANS --- CalOptima shall review and approve Physician termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Physician's capitation withhold to Physician upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Physician of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply

Physician's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Physician financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Physician insolvency. CalOptima shall release to Physician financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Physician may contract with out-of-county facilities for Covered Services for CalOptima Members provided that Physician ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 MEMBER LIAISON PROGRAM (MLP) --- Physician shall establish and maintain support for the Member Liaison Program, including but not limited to:

12.2.1 Providing SPD Members and their caregivers with assistance to navigate the Medi-Cal managed care system;

12.2.2 Coordinating the range of Covered Services needed by SPD Members and assisting SPD Members in understanding and utilizing Physician's referral process;

12.2.3 Ensuring SPD Members receive appropriate and timely referrals;

12.2.4 Identifying barriers faced by SPD Members and integrating recommendations into the delivery system to improve access;

12.2.5 Keeping Physician and Participating Providers educated and sensitive to the needs of persons with disabilities;

12.2.6 Assisting PCPs to fully understand individual SPD Members' needs and provide physicians with access to the many community based resources available;

12.2.7 Providing feedback to CalOptima regarding necessary program modifications/enhancements;

12.2.8 Providing access to SPD Members information necessary for coordination of Covered Services across all Physician departments;

12.2.9 Assisting in the promotion, outreach and community awareness of the MLP.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards, are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Physician's Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements; (xvi) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvii) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xviii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Physician or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as

submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP..

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the Physician's Capitation Payment.

13.1.2.2 Physician may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause – Notwithstanding, and in addition to, any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Physician may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Physician shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, Physician shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of Physician.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Physician in the event that Physician's membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of Physician's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Physician fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should Physician fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Physician that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should Physician fail to comply with requirements for Physician's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR PHYSICIAN INSOLVENCY --- If Physician becomes insolvent, Physician shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against Physician or a principal Subcontractor, Physician shall assure that all Physician's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician until Physician fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining

any and all withheld amounts as necessary to ensure that all Physician obligations have been met.

13.11 TERMINATION BY PHYSICIAN FOR CAUSE --- Provided that Physician is not in default hereunder, Physician may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to Physician under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to Physician any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW--- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Physician in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Physician shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- CalOptima may establish key performance measures of Physician to set minimum contract performance thresholds and/or pay financial incentives to Health Networks and Physician groups. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician, terminate this Contract, and establish Capitation Rates and other payments to Physician.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Physician agrees as follows:

13.14.1 CalOptima reserves the right to require Physician, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that Physician Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Physician terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive

reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks or Physician groups, Physician shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event Physician elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION – Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF PHYSICIAN --- CalOptima and Physician agree that Physician and any agents or employees of Physician, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE--- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. Physician shall be required to bring all legal proceedings against CalOptima in State courts located in Orange

County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION ---Physician agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima , as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician or Subcontractor; (iii) the merger, reorganization, or consolidation of Physician or Subcontractor with another entity with respect to which Physician or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Physician or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Physician or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician hereby acknowledge and agree that the obligations of

CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Physician agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the Physician certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from

participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Physician is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Physician knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician agrees to comply with all applicable standards, orders, or requirements

issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION—

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled "Standard Form-LLL Disclosure of Lobbying Activities") if such recipient has made or has agreed to make any payment using non-appropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of

influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: Director of Contracting
505 City Parkway West
Orange, California 92868
To: Physician
_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- Physician shall ensure that Physician and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code sections 900 et seq.),

including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2020.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Contract:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	-See Transportation-		
Amniocentesis	X		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	X		
Facility component		X	
Birth Control	-See Family Planning-		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
CBAS			**CalOptima (Claims)**
	Physician	**Hospital Budget**	**Other**
CHDP	-See Pediatric Preventative Services-		
Chemotherapy			
Professional component	X		
Outpatient Facility component		X	
Medication	-See Medication-		

Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services			
Professional component (Other than provided by Dentist)			
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component			
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment	**X**		

	Physician	Hospital Budget	Other
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	

Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)	**X**		
Medical Nutrition Services	**X**		
Occupational Therapy	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	**X**		
Mental Health – Specialty Outpatient			**OC HCA/ State**
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	**X**		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		

	Physician	Hospital Budget	Other
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables	***- See Medications -***		
Immunizations	***- See Preventive Services -***		
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	

	Physician	Hospital Budget	Other
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission			
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Patial Hospitalziation Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	

	Physician	Hospital Budget	Other
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Ttreatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		

	Physician	Hospital Budget	Other
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	*- See Medication -*		
Physical Therapy	*- See Rehabilitation -*		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	*- See Diagnostic Services -*		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	*- See Long Term Care Services -*		
Short stay	*- See Hospitalization -*		
Speech Therapy	*- See Rehabilitation -*		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT C
Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates
Term: Effective _____

Hospital Budget Amount Allocation and Capitation Payment to Physician. Monthly, during the term of this Contract, CalOptima shall (i) allocate to the Shared Risk Pool an amount equal to the Hospital Budget Capitation Amount (PMPM) set forth below multiplied by the number of Members assigned to Physician for each such month ("Hospital Budget Capitation Allocation"), and (ii) except as otherwise provided in Attachment E-2, or elsewhere within the Contract, pay the Capitation Payment set forth below to Physician for the provision of Covered Services under this Contract. Risk pool operations and distributions shall be governed by Attachment E-2 to this Contract.

Aid Code Category	Age & Gender Category	**Base Physician**	**Hospital Risk Pool**

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines)

- Payment rates shall be as follows:
  - Physician payment -------
  - Hospital payment --------

Whole Child Model Base Capitation Rates

The following base rates for Whole Child Model are subject to the application of risk adjustment and age/gender factors.

- Hospital $
- Physician $

For the Whole Child Model Program, in order to mitigate the variability in material cost differences between different periods and among different providers, Physician will be eligible for interim reimbursement for catastrophic cases and a retrospective risk corridor as determined by CalOptima.

Funding for PCC

In addition to those amounts described above, Physician shall receive Xdollars and X cents ($X) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups. CCS member is identified by their CCS Eligible condition as determined by the local CCS Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E–1

Capitation Rates for Adult Expansion Members

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least X percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum X percent MLR, CalOptima will be required to return the difference between X percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds X percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

(insert table)

Specialist Physician Reimbursement - For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least X% of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines)

- Payment rates shall be as follows:
  - Physician payment -------
  - Hospital payment --------

Funding for PCC – Effective October 1, 2018

In addition to those amounts described above, Physician shall receive X dollars and X cents ($X) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups and CCS member is identified by their CCS Eligible Condition as determined by the local CCS Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or

a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E-2

Shared Risk Program

1. Shared Risk Pool. CalOptima and Physician are establishing the Shared Risk Pool as described in this Attachment, which shall be administered by CalOptima and separately accounted for on CalOptima's books. As provided in the previous contract, any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract and any expenses from a previous Shared Risk Period received after the end of that pervious Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

1.1 Shared Risk Services—Definition. Shared Risk Services means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("Shared Risk Hospital Amount(s)"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as the "special tertiary rate" and "high-cost exclusions," shall not be included in Shared Risk Services.

1.2 Shared Risk Budget. In addition to the Hospital Budget Capitation Allocation to the Shared Risk Pool set forth in Section 1 of this Attachment, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) monies recovered from coordination of benefits, and (b) any reinsurance coverage amounts collected or allocated. Shared Risk Costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including, but not limited to, overpayments.

1.3 Shared Risk Expenses. Monthly, during the term of this Contract, the following expenses and charges ("Shared Risk Expenses") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Hospital Amounts paid to Hospitals for Shared Risk Services provided to Members, (b) any reinsurance premiums paid by CalOptima that are allocable to the shared risk pool, (c) an estimated amount of IBNR expense (defined below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (d) administrative expenses at a rate of one dollar and sixty cents ($1.60) per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses.

1.4 Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

1.4.1 Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined below), CalOptima shall produce a written report showing all allocations, deposits, expenses and disbursements with respect

to the Shared Risk Pool during that quarter and the Shared Risk Period to date. Each quarterly Report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2 Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period, CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget Allocations made in that semi-annual period minus claims paid for services rendered in that semi-annual period minus a full allocation for Incurred But Not Reported (IBNR) claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician, from the Hospital Budget Allocation, an amount equal to sixty percent (60%) of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5 Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("Shared Risk Period").

1.5.1 Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account incurred but not reported ("IBNR") expenses, regardless of when paid, provided that only those expense items received within (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2 Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "Budget Deficit"), an amount equal to sixty percent (60%) of such Budget Deficit, plus the amount of any Semi-Annual distributions, shall be carried forward as a charge against any future distributions under section 1.5.3.

1.5.3 Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "Budget Surplus"), an amount equal to sixty percent (60%) of such Budget Surplus shall be paid to Physician by CalOptima only after any Semi-Annual distributions have been deducted from the sixty percent (60%) of the Budget Surplus allocable to Physician.

1.5.4 If Physician elects to move from existing contracted shared risk group model to another contract model, Physician's shared risk pool shall not be in deficit.

2. eports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

   Physician shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30) day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the 30 day review period.

3. Settlement in the Event of Termination**.** Notwithstanding anything in this Attachment or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 13 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) calendar days following the termination of this Contract in accordance with Section 1.5 of this Attachment.

4. Obligations of Physician. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician shall provide CalOptima with a report in a form acceptable to CalOptima. If, in CalOptima's reasonable opinion, Physician consistently fails to provide such reports to CalOptima, Physician shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. Prohibition on Other Agreements with Hospitals. During the term of this Contract, Physician shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician without the prior written approval of CalOptima, and upon any violation of this provision by Physician, this Contract shall be subject to termination pursuant to Section 13.1. of the Contract.

6. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used, separating the combined TANF aid categories from all others, and acute inpatient expenses from all other Hospital Budget expenses. Year-end IBNR will be calculated using claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "claims paid through" date, and subsequent claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

7. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 13.1.

ATTACHMENT E-3

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-3) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-3.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-3:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-3, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-3 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase,

CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-3 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-3, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a X percent (X%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a X% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-3 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-3, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-3, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT F –1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F – 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C , Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g , Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

AMENDMENT I TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT I TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of October 1, 2019 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____. ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician wish to enter into this amendment to restate the Division of Financial Responsibilities and Formulary Medical Supplies as well as provide information and requirements related to supplemental payments for certain home health agency services.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility" shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I.

2. Attachment C, "Formulary Medical Supplies" shall be deleted in its entirety and replaced with the attached Attachment C – Amendment I.

3. Attachment E-4, "Supplemental Payment for Home Health Agency Services", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____. have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services
Amendment I

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party				
	Physician		**Hospital**		**Other**
Acupuncture	**X**				
Allergy Testing & Treatment					
Testing	**X**				
Serum	**X**				
Immunotherapy injections	**X**				
Ambulance	***- See Transportation -***				
Amniocentesis	**X**				
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)					
Professional component	**X**				
Facility component			**X**		
Birth Control	***- See Family Planning -***				
Blood and Blood Products					
From blood bank			**X**		
Transfusions, blood and blood components			**X**		
Autologous Transfusion (including collection of)			**X**		
Outpatient Transfusion, Blood and Blood Components			**X**		
Breast Implant (post-mastectomy) or Removal (medically necessary only)					
Professional component	**X**				
Facility component			**X**		
Breast Reconstructive Surgery (after cancer)					
Professional component	**X**				
Facility component			**X**		
CBAS					***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***				
Chemotherapy					
Professional Component	**X**				
Outpatient Facility Component			**X**		
Medication	***- See Medication -***				

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)	**X**				
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				

	Physician		Hospital		Other
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				

	Physician		Hospital		Other
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				

	Physician		Hospital		Other
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				

	Physician		Hospital		Other
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component	**X**				
Outpatient facility component	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***

	Physician		Hospital		Other
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***					
[2] ***Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.***					

ATTACHMENT C

Amendment I

Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

Respiratory Items

- Inhaler Assist Devices
- Nasal Aspirator
- Peak Flow Meters, Non-Electric

Contraceptive Items

- Condoms
- Diaphragms

Diabetic Supplies

- Blood Glucose Monitors (excludes Continuous Glucose Monitors which are covered as DME)
- Insulin Syringes
- Lancets
- Lancet Auto Injectors
- Blood Glucose Test Strips
- Urine Test Strips
- Alcohol Pads

ATTACHMENT E-4

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (X%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by fifty percent (X%) effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, Physician will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the Physician's reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

AMENDMENT II TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT II TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **_____.** ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Health Homes Program.

NOW, THEREFORE, the parties agree as follows:

1. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

"1.102 Community-Based Care Management Entity (CB-CME) means Physician when providing Health Homes Program (HHP) services to HHP Members pursuant to this Contract.

1.103 Health Homes Program or "HHP" means all of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for provision of HHP services that provide supplemental services to HHP eligible and enrolled Members by coordinating and integrating the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed for chronic conditions.

1.104 HHP Member who is HHP enrolled, and continuously participating in the HHP and assigned to the Physician.

1.105 HHP Multi-Disciplinary Care Team means a team of staff employed or contracted by the Physician, as a CB-CME, that provides HHP services to HHP Members."

2. Section 6.22 shall be added as follows:

"6.22 HEALTH HOMES PROGRAM ---

6.22.1 Physician shall begin participating in CalOptima Health Homes Program, as follows: (i) Effective January 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible chronic physical conditions and substance use disorders; and (ii) Effective July 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible serious mental illness.

6.22.2 Physician shall be responsible for providing and coordinating HHP services as one of the designated Community-Based Care Management Entities (CB-CMEs). Physician, as a CB-CME, shall ensure its systems and infrastructure are in place to provide HHP services to HHP Members.

Physician, as a CB-CME, shall satisfy the CB-CME qualification standards as defined by DHCS and CalOptima Policy, and CB-CME certification requirements as described in DHCS HHP Program Guide.

6.22.3 Physician shall comply with all State and federal requirements related to HHP and HHP requirements determined by DHCS, including the All Plan Letter related to Health Homes Program requirements and the HHP Program Guide. Physician, as a CB-CME, shall implement CalOptima Health Homes Program in accordance with this Contract and CalOptima Policies. Physician shall ensure that Physician staff who will be delivering HHP services complete training required by CalOptima and DHCS prior to participating in the administrative of the HHP.

6.22.4 Physician, as a CB-CME, shall be responsible for coordinating care with HHP Members, Providers, and other agencies as appropriate. Physician shall provide the following six (6) core HHP service categories for HHP Members: (i) Comprehensive care management; (ii) Care coordination; (iii) Health promotion; (iv) Comprehensive transitional care; (v) Individual and family support services; and (vi) Referral to community and social supports.

6.22.5 Physician shall maintain an aggregate minimum care coordinator ratio as defined by DHCS. Physician shall ensure the establishment of HHP Multi-Disciplinary Care Teams to provide HHP services, as set forth in CalOptima Policy GG.1331.

6.22.6 Physician shall ensure availability of Providers with experience working with people who are chronically homeless, pursuant to Welfare & Institutions Code section 14127.31(d)(1)(B).

6.22.7 Physician shall establish, as necessary, contractual relationships with organizations to provide HHP services (including but not limited to office visit accompaniment, housing navigator, individual housing transition services, and individual housing and tenancy sustaining services), and contractual or non-contractual relationships to provide linkages to community and social support services. Regardless of the subcontracting arrangement, Physician shall retain overall responsibility for all CB-CME duties and responsibilities set forth in this Contract and CalOptima Policies.

6.22.8 Physician shall conduct outreach and engagement activities for HHP-eligible Members who are not enrolled in HHP. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent to HHP participation may be oral or in writing and shall be documented by the Physician's Customer Service staff or HHP Multidisciplinary Care Team staff prior to the Member's participation in HHP. CalOptima and Physician will coordinate to ensure that Members who meet exclusionary criteria are excluded or disenrolled from the HHP pursuant to the HHP Program Guide and CalOptima Policy GG.1350.

6.22. 9 Physician, as a CB-CME, shall complete a health needs assessment (HNA) and develop a health action plan (HAP) for each HHP Member. Physician shall ensure case conferences are conducted by the HHP Multidisciplinary Care Team and the HHP Member's HNA and HAP are updated as necessary.

6.22.10 Physician may use HHP funding to make payments to HHP Members' network Providers who are not included formally on the Physician's HHP Multi-Disciplinary Care Team, but who are responsible for coordinating with the Physician's HHP care coordinator to conduct case conferences and to provide input to the health action plan (HAP).

6.22.11 In addition to other provisions of this Contract, Physician shall comply with CalOptima Policies GG.1331, GG.1350 and FF.4001 related to CB-CME duties and responsibilities, including engagement activities, the DHCS HHP Program Guide, and CB-CME requirements set forth in Welfare & Institutions Code, section 14127.3(d)(1).

6.22.12 Physician's Agent's Qualifications. Physician shall verify the qualifications of all agents (including Physician staff) providing services under this Contract consistent with the services to be provided under the Health Homes Program. In addition, for agents that enter into Members' homes or have face-to-face contact with Members, Physician shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Physician shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

6.22.13 HHP Data Sharing. CalOptima and Physician agree to exchange available information and data as required by DHCS for the HHP, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of HHP Members. CalOptima and Physician shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements, and other federal and California state laws and regulations, including applying the minimum necessary standard, when applicable. Further, Physician shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an HHP Member's valid authorization for release of health information and a legal exception does not apply, Physician may not release such information without the HHP Member's valid authorization.

6.22.14 HHP Data Reporting. Physician shall submit to CalOptima complete, accurate, reasonable and timely data reports in the manner and form acceptable to CalOptima in order for CalOptima to meet its data reporting requirements to DHCS for the HHP."

3. Attachment E-5, "Funding for Health Homes Program", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-5

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to Physician for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

    1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

    - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
    - Member is enrolled in the HHP;
    - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the Physician, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the Physician;
    - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
    - If applicable, the Physician paid the provider for the HHP core services; and
    - The Physician authorized such HHP core services.

    $ PMPM (January – June 2020)
    $ PMPM (July – December 2020)

2. Engagement Activities Supplemental Capitation Payment

    2.1 Subject to Section 2.2 of this Attachment E-5, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

    - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
    - The Physician conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
    - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
    - If applicable, the Physician authorized and paid the provider for such engagement

    $ PMPM (January – June 2020)
    $ PMPM (July – December 2020)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. Physician shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15^{th}) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT III TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT III TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____. ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract for the allocation and distribution of Intergovernmental Transfer (IGT) 6 and 7 Funds for Whole-Child Model (WCM) Startup Expenses incurred by Physician. IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 1–7 funds are designated for enhanced/additional benefits for Medi-Cal beneficiaries.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-6, "Whole-Child Model (WCM) Start-up Expenses Reimbursement", shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____. have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-6

Whole-Child Model (WCM) Program Start-up Expense Reimbursement

This attachment sets forth the program of additional compensation for Whole Child Model (WCM) start-up expenses, as authorized by the CalOptima Board of Directors at its December 5, 2019, meeting.

A. Reimbursement Available. There are two parts of the expense related reimbursement payments available to Physician.

1. Flat Rate: Physician shall receive a one-time payment amount of $X; AND,

2. Variable Rate: If expenses for the implementation, as described in this Attachment, exceed the $X flat rate, an additional amount of up to $X per member per month, shall be reimbursed to Physician. This maximum funding amount has been calculated based on the average number of CCS Members assigned to Physician from July through September 2019.

B. Reimbursable Expenses. Reimbursement under the variable rate reimbursement category is limited to those expenses that were incurred prior to July 1, 2019. There are three broad categories of reimbursable expenses for the variable rate reimbursements, as follows:

1. Personnel Expenses—These expenses relate to the reassignment, recruitment and training of administrative personnel for implementation of the WCM, including both the cost of diverting existing staff (such as reassigning claims payment staff to prepare WCM-specific claims processing policies, procedures, and routines), the cost of recruiting new staff to carry out WCM-specific tasks (such as utilization management, case management, and claims processing for WCM services), and the cost of training (such as bringing in outside trainers, preparing training materials, and overseeing on-line training activities for staff on WCM-specific matters).

2. Systems and Infrastructure—These expenses include those expenses involved in establishing a DHCS-compliant WCM provider network, such as contracting and credentialing additional CCS-approved physicians and facilities; necessary modifications to electronic data systems; additional office equipment for new WCM-specific staff; acquisition of new software or new modules for existing software made necessary by operation of the WCM; and development of program reporting capabilities to meet the requirements of the CalOptima WCM program.

3. Other Expenses—This category includes other expenses incurred in preparation for the implementation of the WCM, such as member notifications, educational materials for members, providers, and/or Physician administrative staff, and other items that are dedicated to WCM implementation that are not covered by reimbursable expense categories 1. and 2.

C. Reimbursement

1. The flat fee reimbursement shall be paid by CalOptima on or before March 1, 2020.

2. The variable rate reimbursement shall be paid by CalOptima within thirty (30) days of confirmation that the following have been submitted, are consistent between the attestation and invoice (see below), are consistent with the costs that are reimbursable, and are accepted as complete:

2.1. An attestation, in the format designated by CalOptima, indicating the general nature and amount of expenditures incurred prior to July 1, 2019, for each of the three broad reimbursable expense categories, signed by an authorized signer for Physician.

2.2. A detailed invoice specifically describing the costs incurred, prior to July 1, 2019, in preparation for implementation of the WCM, as follows:

2.2.1 Personnel Costs—For Physician personnel costs in each category identify the job title, hours, and total compensation incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.2. Contractual Services—For services obtained from other than Physician personnel, indicate each contracted party, a general identification of the services provided, and the costs incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.3 Goods/Materials—For goods and materials, indicate the type of goods procured, from whom the goods were acquired, for what purpose the goods were used, and the cost of each type of goods obtained, and how the expenses relate to preparation for implementation of the WCM.

D. Audit.

1. CalOptima is not requiring that supporting documentation, such as contracts and invoices from providers of goods and services, or employment records for personnel undertaking preparations for implementation of the WCM, be provided with the attestation and invoices. However, Physician shall maintain such records in a reasonably accessible manner for inspection by CalOptima or its designated auditor.

2. CalOptima, or its designated auditor, shall audit Physician's records during the annual financial audit to verify that the expenses were incurred as reported in the invoicing and attestation. Reimbursement of both flat and variable rate start-up expenses are subject to recoupment if substantiating documentation is not made available. Substantiating documentation may include, but not be limited to, salary and payroll information as described in Section 1.1.2; general ledger entries identifying the start-up expenses; contracts and invoices from third party providers of goods and services, and copies of cancelled checks to support payment of expenses.

3. Any variable rate reimbursement amounts that are found to not have been incurred, or not to be supported by sufficient documentation, shall be disallowed retroactively. Such disallowed amounts will constitute an overpayment and will be returned to CalOptima or recovered through offset, as provided elsewhere in this Contract.

E. Disputes. In the event that CalOptima disallows any expense incurred and properly attested and invoiced, Physician shall have the right to pursue those remedies identified in this Contract and CalOptima Provider Dispute and Appeals policies.

AMENDMENT IV TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IV TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the coronavirus known as COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-7, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E-7

MEDI-CAL RATE ENHANCEMENT

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). Pursuant to the action taken by CalOptima Board of Directors on April 2, 2020, in anticipation of a fluctuation in utilization by Medi-Cal members and the need for flexible services due to COVID-19, CalOptima amends the current Medi-Cal capitation base rate levels set forth in Attachment E to increase them by [redacted] for the period commencing April, 1 2020 and continuing through, and including, June 30, 2020.

AMENDMENT V TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT V TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2020, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure, revise the capitation rates and the shared risk program.

NOW, THEREFORE, the parties agree as follows:

1. Section 2.7.18. of the Contract, and any references thereto, shall be renumbered as Section 2.7.19, and new Section 2.7.18 shall be added to the Contract as follows:

   "2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and Physician shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-3, by Physician to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to Physician."

2. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

   "15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2021."

3. ATTACHMENT E shall be deleted and replaced with the attached ATTACHMENT E - AMENDMENT V "Capitation Rates".

4. ATTACHMENT E-1 shall be deleted and replaced with the attached ATTACHMENT E-1 - AMENDMENT V "Capitation Rates for Adult Expansion Members".

5. ATTACHMENT E-2 shall be deleted and replaced with the attached ATTACHMENT E-2 - AMENDMENT V "Shared Risk Program".

6. ATTACHMENT E-3 “Distribution of Proposition 56 Funding” and Addendums to this Attachment shall be deleted and replaced with the attached ATTACHMENT E-3 – AMENDMENT V, “Distribution of Proposition 56 Funding”.

7. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT V

Capitation Rates

Effective July 1, 2020

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive X dollars and X cents ($X) per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset

Physician’s future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E-1 – AMENDMENT V

Capitation Rates for Adult Expansion Members

Effective July 1, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Expansion	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least X% of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive eight dollars and ninety-four cents ($X) per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible Condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Member's with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E-2 – AMENDMENT V

Shared Risk Program

1. Shared Risk Pool. CalOptima and Physician are establishing the Shared Risk Pool as described in CalOptima Policy FF.1010, Shared Risk Pool, which shall be administered by CalOptima and separately accounted for on CalOptima's books. As provided in the previous contract, any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract and any expenses from a previous Shared Risk Period received after the end of that previous Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

   1.1 Shared Risk Services—Definition. Shared Risk Services means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("Shared Risk Hospital Amount(s)"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as "high-cost exclusions", shall not be included in Shared Risk Services.

   1.2 Shared Risk Budget. In addition to the Hospital Budget Capitation Allocation to the Shared Risk Pool set forth in Section 1 of this Attachment, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) supplemental obstetrics (OB) delivery care payments as set forth in CalOptima Policy FF.1005f, Special Payments: Supplemental OB Delivery Care Payment, and (b) per CalOptima Policy FF.1007, Health Network Reinsurance Coverage, any reinsurance coverage amounts collected or allocated. Shared Risk Costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including, but not limited to, overpayments. The Shared Risk Budget shall not include any amounts for Members eligible for the WCM Program.

   1.3 Shared Risk Expenses. Monthly, during the term of this Contract, the following expenses and charges ("Shared Risk Expenses") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Hospital Amounts paid to Hospitals for Shared Risk Services provided to Members, (b) an estimated amount of IBNR expense (defined below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (c) administrative expenses at a rate of X dollar and X cents ($X) per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses. The Shared Risk Expenses shall not include any amounts paid for Members eligible for the WCM Program.

   1.4 Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

1.4.1 Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined below), CalOptima shall produce a written report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool during that quarter and the Shared Risk Period to date. Each quarterly Report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2 Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period, CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget Allocations made in that semi-annual period minus claims paid for services rendered in that semi-annual period minus a full allocation for Incurred But Not Reported (IBNR) claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician, from the Hospital Budget Allocation, an amount equal to X percent (X%) of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5 Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("Shared Risk Period").

1.5.1 Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account incurred but not reported ("IBNR") expenses, regardless of when paid, provided that only those expense items received within (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2 Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "Budget Deficit"), an amount equal to X percent (X%) of such Budget Deficit, plus the amount of any Semi-Annual distributions, shall be carried forward as a charge against any future distributions under Section 1.5.3.

1.5.3 Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "Budget Surplus"), an amount equal to X percent (X%) of such Budget Surplus shall be paid to Physician by

CalOptima only after any Semi-Annual distributions have been deducted from the X percent (X%) of the Budget Surplus allocable to Physician.

1.5.4 If Physician elects to move from existing contracted shared risk group model to another contract model, Physician's shared risk pool shall not be in deficit.

2. Reports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

Physician shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30) day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the 30 day review period.

3. Settlement in the Event of Termination**.** Notwithstanding anything in this Attachment or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 13 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) calendar days following the termination of this Contract in accordance with Section 1.5 of this Attachment.

4. Obligations of Physician. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician shall provide CalOptima with a report in a form acceptable to CalOptima. If, in CalOptima's reasonable opinion, Physician consistently fails to provide such reports to CalOptima, Physician shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. Prohibition on Other Agreements with Hospitals. During the term of this Contract, Physician shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician without the prior written approval of CalOptima, and upon any violation of this provision by Physician, this Contract shall be subject to termination pursuant to Section 13.1. of the Contract.

6. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used. Year-end IBNR will be calculated using claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "claims paid through" date, and subsequent claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

7. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 13.1.

ATTACHMENT E-3 -AMENDMENT V

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-3) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-3.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-3:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    b. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    c. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-3, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-3 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-3 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-3, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a X percent (X%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-3 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

15. Notwithstanding other provisions of this Attachment E-3, effective July 1, 2020, CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-3, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-3, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician wish to enter into this amendment to revise the Division of Financial Responsibilities, revise the Termination for Convenience provision as well as modify language as appropriate to align with all Health Care Services contracts.

NOW, THEREFORE, the parties agree as follows:

1. Section 1.16, "CalOptima Regulators", shall be deleted in its entirety and replaced with the following:

   "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforce applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Health Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

2. Section 1.22, "Community Liaison" or "CL", shall be deleted and intentionally left blank.

3. Section 1.23, "Community Liaison Program" or "CLP", shall be deleted and intentionally left blank.

4. Section 1.55, "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)", shall be deleted in its entirety and replaced with the following:

   "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

5. Section 1.64, "Memorandum/Memoranda of Understanding" or "MOU", shall be deleted in its entirety and replaced with the following:

   "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements,

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including but not limited to the Coordination and Provision of Public Health Care Services Contract.

6. Section 1.84, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)", shall be deleted in its entirety and replaced with the following:

"Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol."

7. Section 1.95, "Subcontract", shall be deleted in its entirety and replaced with the following:

"Subcontract" means a written agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

8. Section 1.96, "Subcontractor", shall be deleted in its entirety and replaced with the following:

"Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with Physician to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract."

9. Section 2.3.2 shall be deleted in its entirety and replaced with the following:

"Commercial General Liability/Commercial Automobile Liability:
Physician shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Physician's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract."

10. Section 2.3.8 shall be deleted in its entirety and replaced with the following:

"Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Physician shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Physician shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request."

11. Section 2.7.12, "Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments", shall be deleted in its entirety and replaced with the following:

"Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy."

12. Section 2.7.13, "Family Planning Provider Payments", shall be deleted in its entirety and replaced with the following:

"Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than X percent (X%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy."

13. Section 2.7.14, "Sexually Transmitted Disease Treatment Payments", shall be deleted in its entirety and replaced with the following:

"Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than X percent (X%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information."

14. Section 2.7.15, "HIV Testing and Counseling Payments", shall be deleted in its entirety and replaced with the following:

"HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than X percent (X%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician."

15. Section 3.4, "CALOPTIMA LOGO", shall be deleted in its entirety and replaced with the following:

"CALOPTIMA LOGO --- Physician shall not display the CalOptima logo on any of Physician's written communication to Members without prior written approval by CalOptima."

16. Section 3.9, "SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. Physician shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI

and CMS requirements for reporting information about Offshore Subcontracts. Physician shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, Physician shall require all Subcontracts contain the following:"

17. Section 3.9.2 shall be deleted in its entirety and replaced with the following:

"An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;"

18. Section 3.9.7 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;"

19. Section 3.9.8 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;"

20. Section 3.9.10 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;"

21. Section 3.9.12 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;"

22. Section 3.9.20 shall be deleted in its entirety and replaced with the following:

"An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement);"

23. Section 3.9.25 shall be deleted in its entirety and replaced with the following:

"An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and"

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24. Section 3.9.26 shall be added as follows:

"Subcontractor's agreement to provide Physician with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request."

25. Section 3.17, "MEDICAL AND ADMINISTRATIVE RECORDS", shall be deleted in its entirety and replaced with the following:

"MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). Physician shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site."

26. Section 3.19.1 shall be deleted in its entirety and replaced with the following:

"Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years."

27. Section 3.24, "FRAUD AND ABUSE REPORTING", shall be deleted in its entirety and replaced with the following:

"FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or Physician's employees, within five (5) working days of the date when Physician first becomes aware of or is on notice of such activity."

28. Section 3.24.2 shall be deleted in its entirety and replaced with the following:

"Physician shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program."

29. Section 3.28, "COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations."

30. Section 3.30, "COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s))", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. Physician agrees to require Subcontractors to comply with applicable requirements of such MOUs."

31. Section 3.42, "OBLIGATIONS UNDER PRIOR CONTRACT", shall be deleted in its entirety and replaced with the following:

"OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between Physician and CalOptima pursuant to which Physician agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members."

32. Section 4.2, "EMERGENCY CARE", shall be deleted in its entirety and replaced with the following:

"EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week."

33. Section 4.7, "ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES", shall be deleted in its entirety and replaced with the following:

"ALCOHOL MISUSE SCREENING AND COUNSELING --- Physician shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC."

34. Section 5.6.8 shall be deleted in its entirety and replaced with the following:

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"In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements."

35. Section 5.15, "SPECIALIST GEOGRAPHIC DISTRIBUTION", shall be deleted in its entirety and replaced with the following:

"SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence."

36. Section 6.4, "QUALITY IMPROVEMENT PROGRAM", shall be deleted in its entirety and replaced with the following:

"QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:"

37. Section 6.8.3.3 shall be deleted in its entirety and replaced with the following:

"An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS."

38. Section 6.15.1 shall be deleted and intentionally left blank.

39. Section 6.15.13 shall be deleted in its entirety and replaced with the following:

"Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by Physician pursuant to DHCS requirements and CalOptima Policies."

40. Section 10.2, "COMPREHENSIVE PHYSICIAN AUDIT", shall be deleted in its entirety and replaced with the following:

"COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut

and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician."

41. Section 10.7, "MOU AVAILABILITY", shall be deleted in its entirety and replaced with the following:

"MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website."

42. Section 10.10, "PROVIDER COMPLAINT SYSTEM", shall be deleted in its entirety and replaced with the following:

"PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and Physician shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system."

43. Section 12.2, "MEMBER LIAISON PROGRAM (MLP)", shall be deleted and intentionally left blank.

44. Section 13.1, "SANCTIONS AND TERMINATIONS FOR CAUSE," shall be deleted in its entirety and replaced with the following:

"SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing

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Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:"

45. Section 13.9, "TERMINATION FOR CONVENIENCE", shall be deleted in its entirety and replaced with the following:

"TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination."

46. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment VI.

47. Attachment E, "Capitation Rates", shall be deleted and replaced with the attached Attachment E – Amendment VI.

48. Attachment E-5, "Funding for Health Homes Program (HHP)" shall be deleted in its entirety and replaced with the attached Attachment E-5 – Amendment VI.

Commented [TC1]: PHC-P its under Attachment E-4 and needs to be updated on amendment

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT A – AMENDMENT VI

CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

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	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)			**X**		
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		

	Physician		Hospital		Other
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)'s***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				

	Physician		Hospital		Other
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				

	Physician		Hospital		Other
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***

	Physician		Hospital		Other
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation *					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
** CCS specific services are paid per Article 9.*					
[1] *Services are the responsibility of MTP if provided under the MTP program.*					
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*					

ATTACHMENT E – AMENDMENT VI

Capitation Rates

Effective January 1, 2021

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

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Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive X[redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

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Attachment E-5 – Amendment VI

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to Physician for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

   1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
   - Member is enrolled in the HHP;
   - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the Physician, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the Physician;
   - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
   - If applicable, the Physician paid the provider for the HHP core services; and
   - The Physician authorized such HHP core services.

   $X PMPM (January – June 2020)
   $X PMPM (July – December 2020)
   $X PMPM (January – December 2021)

2. Engagement Activities Supplemental Capitation Payment

   2.1 Subject to Section 2.2 of this Attachment E-5, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
   - The Physician conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
   - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
   - If applicable, the Physician authorized and paid the provider for such engagement

   $X PMPM (January – June 2020)
   $X PMPM (July – December 2020)
   $X PMPM (January – December 2021)

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2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. Physician shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15th) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT VII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and Physician desire to amend the Contract to include the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. ATTACHMENT E-8 "MEDI-CAL RATE ENHANCMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Physician** have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT E-8

MEDI-CAL RATE ENHANCEMENT

For the period from January 1, 2021, through June 30, 2021, the base physician and base hospital capitation rates set forth in Attachment E – Amendment VI for the Child/Adult and SPD aid code categories shall be increased by X%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E – Amendment VI, Adult Expansion Member capitation rates in Attachment E-1 Amendment V, or the Health Homes Program supplemental capitation payments in Attachment E-5 – Amendment VI.

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MEDI-CAL

HMO

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

HMO

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered into by and between Orange County Health Authority, a public agency, dba CalOptima, ("CalOptima"), and _____ ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein.

D. HMO is a restricted health care service plan licensed under the California Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code § 1340 et seq.), as amended, that provides health care services to its enrolled Members.

E. CalOptima and HMO desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the HMO and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and, in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 “Advance Directive” means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 “Aid Code” means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 “American Indian” means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 “American Indian Health Care Provider” means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).”

1.7 “American Indian Health Service Programs” means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.”

1.8 “Approved Drug List” means CalOptima’s continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 “California Children’s Services (CCS)” means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 “California Children’s Services (CCS) Eligible Condition(s)”, means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 “California Children’s Services (CCS) Program” means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 “CCS Provider” or “CCS-Paneled Provider(s)” means any of the following providers when used to treat Members for a CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or HMO.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, HMO, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the HMO by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi- Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or from one Health Network to another Health Network; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq. that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in the Health Networks.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted

by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and HMO. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on HMO, DHCS Medi-Cal Managed Care Policy Division Policy Letters and, Contract Interpretation.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program."

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider, which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network regardless of Health Network reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the HMO for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the HMO(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act") and who is signatory to this Contract.

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or a health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act), which is owned or operated by HMO or with which HMO has a Subcontract to provide Covered Services under this Contract.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of HMO which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within HMO's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and the HMO.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled in the HMO.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with HMO to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of HMO. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 “Pediatric Preventive Services” or "PPS" means well child services, which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 “Perinatal Support Services” or “PSS” means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 “Person-Centered Planning” means a highly individualized and ongoing process to develop individualized care plans that focus on a person’s abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 “PHC” and “PHCs” means a physician-hospital consortium/consortia.

1.76 Not Applicable to this Contract.

1.77 “Physician Incentive Plan” means any compensation arrangement between HMO and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 “Practitioner” means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 “Primary Care Physician” or “PCP” means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members “Primary Care Physician” or “PCP” shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.80 “Provider” means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.81 “Quality Indicators” means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.82 "Reinsurance" means coverage provided by CalOptima and any coverage secured by HMO, which limits the amount of risk or liability for the cost of providing Covered Services.

1.83 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care HMO to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

1.84 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing.

1.85 Not Applicable to this Contract.

1.86 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes

1.87 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.88 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.89 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.90 "Specialty Mental Health Services" means:

1.90.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.90.2 Psychiatric inpatient hospital services;

1.90.3 Targeted Care Management services;

1.90.4 Psychiatrist services;

1.90.5 Psychologist services; and

1.90.6 EPSDT supplemental specialty mental health services.

1.91 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.92 "State" means the State of California.

1.93 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.94 "Subcontract" means an agreement entered into by the HMO with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

1.95 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with HMO. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.96 "Sub-delegation" means the process by which HMO expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by HMO in order to meet its obligations under, and the intent of this Contract.

1.97 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

1.98 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.99 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.100 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of HMO – Financial

2.1 Not Applicable to this Contract.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion

2.3 INSURANCE REQUIREMENTS:

2.3.1 Professional/Medical Malpractice:
Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

Hospital providing covered services:
$5,000,000 per incident/$5,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
HMO and each Participating Provider shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
HMO and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:
HMO shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Insurer Ratings: Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or
(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured: Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change: The HMO shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT---HMO shall reimburse the Local Health

Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 HMO FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- HMO shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, HMO shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 SKILLED NURSING FACILITY FINANCIAL RESPONSIBILITY --- HMO shall be financially responsible for Skilled Nursing Facility services daily rate when such services are determined by CalOptima to be in-lieu of acute hospitalization.

2.7 PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - HMO and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which HMO receives payment from CalOptima.

2.7.2 Claims Turnaround Time - HMO shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested by HMO, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, HMO shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima

Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from HMO's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of HMO

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of HMO, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved

corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that HMO fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from HMO for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce HMO Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of HMO, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 HMO shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 HMO shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 HMO's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO group. HMO will receive misdirected claims per CalOptima Policy.

2.7.9.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy, and load them into their system to ensure timely claims processing.

2.7.10 FQHCs Payments - If FQHC, HMO shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services

2.7.11 American Indian Health Service Payments - HMO shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. HMO shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in HMO's provider network, HMO shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than XX (xx%) of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.7.13 Family Planning Provider Payments - HMO shall reimburse non-contracting family planning providers at no less than XX (xx%) of the Medi-Cal fee schedule as identified in CalOptima Policy. HMO shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than XX (xx%) of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. HMO may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to HMO along with billing information.

2.7.15 HIV Testing and Counseling Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than XX (xx%) of the Medi-Cal fee schedule as identified in CalOptima Policy. HMO

shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to HMO.

2.7.16 Information Disclosures To Participating Providers. HMO shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments-

2.7.17.1 HMO shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than XX (xx%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by HMO and the physician and surgeon.

2.7.17.3 For CCS neonatal intensive care units, HMO shall pay the CCS Provider either the equivalent of Medi-Cal fee-for-service rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or HMO's negotiated rates, whichever is higher, for up to 12 months after the transition.

2.7.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- HMO shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party,

recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- HMO shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by HMO and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall HMO cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. HMO shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. HMO shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS, or in child support enforcement cases. If HMO does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then HMO shall follow the procedure above for cost avoidance. If HMO does not reimburse a Provider on a Fee-for-Service basis, then HMO shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 HMO shall have written policies implementing these requirements.

2.9.4 HMO shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 HMO shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 HMO shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 HMO shall demonstrate to CalOptima that where HMO does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues HMO projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- HMO shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%).

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- HMO shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care.

2.12 COOPERATION WITH DMHC --- HMO shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to HMO. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of HMO - Administrative

3.1 STATUTORY REQUIREMENTS --- HMO shall retain at all times during the period of this Contract a valid restricted Knox-Keene license issued by the California Department of Managed Health Care (DMHC).

3.2 EQUAL OPPORTUNITY

3.2.1 HMO and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. HMO and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are

treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. HMO and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state HMO and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 HMO and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of HMO and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 HMO and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of HMO and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 HMO and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 HMO and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive

Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of HMO and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and HMO and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 HMO and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. HMO and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event HMO and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, HMO and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- HMO shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- HMO shall display the CalOptima logo on all HMO's written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. HMO shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 MEMBER INQUIRIES AND CALLS --- HMO shall establish and maintain a call center for receiving and responding to Member inquiries and calls. HMO's call center shall meet requirements established by CalOptima Policies. HMO shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure HMO shall supply reports of call center performance as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, HMO shall ensure that all written Member information provided by HMO to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. HMO shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Member grievances. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES. Except as otherwise limited by the State Contract, this Contract and/or

CalOptima Policies and subject to CalOptima's prior written approval, HMO may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of HMO but shall not absolve HMO of oversight responsibilities. All sub-delegation must be approved by CalOptima. HMO shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. HMO's Sub-delegation to another entity does not alter HMO's ultimate obligation and responsibilities set forth in this Contract. HMO may give a sub-delegate the authority to act on behalf of HMO; but HMO retains oversight and accountability for the sub-delegated function. Accountability means that HMO cannot abdicate responsibility for the function being performed according to the requirements of this Contract, HMO's standards and those established by this Contract and CalOptima Policies. HMO is accountable for all functions performed in its purview whether by HMO, by any sub-delegate or by any sub-sub-delegate. If HMO chooses to sub-delegate a function, HMO must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, HMO shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the HMO and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the HMO and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the HMO evaluates the sub-delegate entity's performance; and

3.8.1.5 The HMO's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the HMO's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the HMO's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The HMO's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The HMO's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 HMO shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 HMO shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of HMO's Members, including those receiving services from a sub-delegate of HMO.

3.8.6 HMO shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve- (12) month period. HMO shall establish standards and performance requirements for sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of HMO in this Contract and in CalOptima Policies. HMO may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group, or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by HMO to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. HMO shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. HMO shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- HMO may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. HMO is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. HMO is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore

entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, HMO shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 to 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10, and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or HMO, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on the HMO;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or comment

on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed by and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event HMO cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with HMO and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract, for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract;

3.9.15 In the event that HMO implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by HMO.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if HMO delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or HMO determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the HMO to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 HMO ORGANIZATION AND OPERATIONS STRUCTURE --- HMO shall comply with the organization and operations structure requirements of applicable laws and regulations. Without limiting the foregoing, HOM shall maintain a full time physician as Medical Director/Chief Medical Officer (CMO) whose responsibilities shall include, but not limited to, the following:

3.10.1 Ensuring that medical decision are: (i) rendered by qualified medical personnel, and (ii) are not unduly influenced by fiscal or administrative management considerations.

3.10.2 Ensuring that the medical care provided meets the standards for acceptable medical care.

3.10.3 Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

3.10.4 Developing and implementing medical policy.

3.10.5 Resolving grievances related to medical quality of care.

3.10.6 Direct involvement in the implementation of Quality Improvement activities.

3.10.7 Actively participate in the functioning of the grievance and appeal procedures.

3.11 ENROLLMENT --- HMO shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to HMO.

3.12 PCP ASSIGNMENT --- HMO shall assign Members who have been automatically assigned to HMO by CalOptima to a PCP within seven (7) days of the Member's assignment to HMO.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- HMO shall mail to a Member or Member's head of household a notice of enrollment and a HMO Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with HMO. All member handbooks and supplements prepared by HMO shall be submitted to CalOptima for approval prior to printing. HMO shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should HMO choose to utilize the CalOptima Member handbook, HMO-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all HMOs' CalOptima Members. CalOptima shall provide HMO with a template for the supplement to the CalOptima member handbook.

3.13.2 If HMO chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, HMO's Member handbook shall contain all information included in the

CalOptima Member handbook and HMO-specific information on each topic as defined by CalOptima Policies.

3.13.3 HMO shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. HMO shall also provide one (1) copy of its enrollment information including its HMO Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- HMO may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- HMO shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- HMO shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. HMO shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

3.17.1 HMO and CalOptima agree to maintain the confidentiality of the Member’s Medi-Cal status and information contained in the Member’s Medical Records in accordance with federal and State law. HMO shall require that all Participating Providers and Subcontractors maintain the confidentiality of a

Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services, in accordance with CalOptima Policies, and shall, at a minimum, contain:

3.17.2.1 Member identification on each page; personal/biographical data in the record.

3.17.2.2 Initial Health Assessment within 120 days of enrollment.

3.17.2.3 Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3.17.2.4 All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

3.17.2.5 The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

3.17.2.6 Allergies and adverse reactions are prominently noted in the record.

3.17.2.7 All informed consent documentation, including the human sterilization consent procedures required by Sections 51305.1 through 51305.6 of Title 22 of the California Code of Regulations, if applicable.

3.17.2.8 Reports of emergency care provided (directly by a contracted provider or through a non-contracted emergency room) and the hospital discharge summaries for all hospital admissions.

3.17.2.9 Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

3.17.2.10 For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive, such as a Durable Power of Attorney for Health Care.

3.17.2.11 Health education behavioral assessment and referrals to health education services.

3.17.3 It is understood that all Participating Provider's and Subcontractors' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at HMO's, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the HMO's, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- HMO and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which HMO or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 HMO shall, upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any

monitoring, inspection or evaluation is made of the premises of HMO or Subcontractor, HMO shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, HMO shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the HMO's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, HMO shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by HMO and Subcontractors pertaining to these services at any time pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, HMO shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at HMO's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the HMO's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of HMO's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of HMO, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time pursuant to 42 CFR section 438.3(h). The monitoring activities will be either

announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to HMO. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and HMO will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period as specified in Section 3.18, HMO and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to HMO's provision of and reimbursement for activities contemplated under the Contract, and to HMO's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign HMO's statement of confidentiality prior to being admitted access to HMO's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the HMO at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; seek recovery of payments made to the HMO; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, HMO shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all

reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by HMO or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 HMO further agrees to timely gather, preserve, and provide to DHCS any records in the HMO's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- HMO and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, HMO shall keep CalOptima informed as to the names of the officers and owners of HMO holding more than five percent (5%) of the stock issued by HMO, and major creditors holding more than five percent (5%) of the debt of the HMO. HMO shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If the provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, HMO shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- HMO shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or HMO's employees, within two (2) working days of the date when HMO first becomes aware of or is on notice of such activity.

3.24.1 HMO shall notify CalOptima, and CalOptima shall notify DHCS prior to HMO conducting any investigations. HMO shall conduct an investigation after notification has been given.

3.24.2 HMO shall establish for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 HMO shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- HMO shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the HMO's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 HMO COMPLIANCE PROGRAM --- HMO shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the HMO annually to ensure that it remains effective. HMO shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- HMO and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("HMO's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to HMO and HMO shall make them available to HMO's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- HMO shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. HMO's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- HMO agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. HMO

acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- HMO agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS ---HMO shall have policies and procedures to verify the Participation Status of HMO's Agents. HMO shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, HMO warrants and agrees as follows:

3.31.1 HMO and HMO's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 HMO shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by HMO or HMO's Agents occurring and/or discovered during the term of this Contract.

3.31.3 HMO shall take immediate action to remove any HMO Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 HMO shall include the obligations of this Section in its Subcontracts.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, and et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, and et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4

of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. HMO and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 HMO and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the HMO nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 HMO shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically

indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 HMO shall act upon all complaints alleging discrimination against Members in accordance, with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 HMO shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. HMO shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 HMO shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. HMO shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. HMO shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. HMO shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, HMO shall provide translation of written member informing materials in the Threshold and Concentration Languages. HMO shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, HMO shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. HMO shall also make materials available to Members in

alternate formats (e.g. Braille, audio, large print) upon request of the Member. HMO shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- HMO shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by HMO or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. HMO shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. HMO shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, HMO must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. HMO shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. HMO shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. HMO shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- HMO shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. HMO shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- HMO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 HMO and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future, within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 HMO shall comply with HIPAA requirements as currently established in CalOptima Policies. HMO shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Health Network HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 HMO and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to HMO, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract. HMO and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima

without prior written authorization from CalOptima. For purposes of this provision, identity shall include, Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with applicable law pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by HMO or its Subcontractors, HMO:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the HMO by DHCS for this purpose.

3.39 REINSURANCE ---CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance.

HMO may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, HMO shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- HMO shall have a process for claims management and administration. HMO shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. HMO shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE--- HMO shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider's or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the HMO being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. HMO shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- HMO acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). HMO shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- HMO shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. HMO shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of HMO's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- HMO shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 HMO SUBCONTRACTS --- In addition to Section 3.9 of this Contract, HMO shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copes of all Subcontracts. HMO shall ensure that all Subcontracts are in writing and require that the HMO and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – HMO understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of HMO under this Contract. In instances where DHCS or CalOptima determines that the HMO or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the

right to (a) amend or revoke the delegation of activities or obligations to the HMO, (b) require the HMO to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. HMO shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of HMO or the oversight of those obligations.

ARTICLE 4
Obligations of HMO – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- HMO shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of HMO, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that HMO is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, HMO shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. HMO shall provide Covered Services to Members and HMO agrees as follows:

4.1.1 HMO shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of HMO as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If HMO's network is unable to provide necessary medical services covered under this Contract to a particular Member, HMO must adequately and timely cover these services out of network for the Member, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 HMO shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective HMO as to the Medical Necessity of the service, except that HMO shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 HMO shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the HMO denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. HMO acknowledges that disputes between the respective HMO and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 HMO shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or HMO, CalOptima's or the HMO's insolvency, or breach of this Contract by the HMO or CalOptima, shall HMO or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit HMO or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. HMO or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's Medical Record. HMO further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the HMO Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the HMO's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the HMO and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 HMO further agrees that, in the event of a violation of this Section by HMO or Subcontractor, including but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against HMO or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- HMO shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). HMO is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 HMO shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if HMO reasonably determines that Emergency Services were never performed.

4.2.2 HMO shall reimburse or authorize reimbursement for facility changes for Emergency Services. HMO is required to reimburse hospital when necessary for all MSE. If the MSE indicates that the Member has an Emergency Medical Condition as defined in Section 1.34, HMO must reimburse or authorize reimbursement, as appropriate for all Covered Services Medically Necessary to diagnose and Stabilize the Member.

4.2.3 HMO shall reimburse those physicians providing services in an Emergency Department with whom HMO has a contract according to the terms of that contract. HMO shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. HMO shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. HMO shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, HMO shall not deny payment for treatment obtained when HMO or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 HMO shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between HMO or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider and Hospital under contract with HMO agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on HMO.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). HMO is financially responsible for post-stabilization services obtained within or outside HMO's network that are pre-approved by a plan provider or other entity representative. HMO is

financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other HMO representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to HMO for pre-approval of further post-stabilization care services.

4.2.8.1 HMO is also financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if HMO does not respond to a request for pre-approval within 30 minutes; HMO cannot be contacted; or HMO's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, HMO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 HMO's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214 HMO is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Section, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Section shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section shall constitute payment in full under this Section, and shall not be subject to subsequent adjustments or reconciliations

by HMO, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by HMO pursuant to this Section.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, HMO is financially responsible for payment for post-stabilization services following an emergency admission. HMO shall reimburse those physicians providing post-stabilization services with whom HMO has a contract according to the terms of that contract. HMO shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- HMO shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- HMO is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, HMO shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. HMO's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services shall not be required.

4.4.1 HMO shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires HMO to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve HMO from financial responsibility for such services.

4.4.2 HMO shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 HMO shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. HMO shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 HMO shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the HMO has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 HMO shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- HMO shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH HMO OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, HMO shall arrange for the timely referral and coordination of Covered Services to which HMO or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES. HMO shall ensure the provision of SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. HMO shall document SBIRT services in Members Medical Record.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network physician without first requesting a referral from a network Primary Care Physician. HMO shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within HMO's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- HMO acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify HMO of the date upon which HMO will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time HMO shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of HMO – Access

5.1 TWENTY FOUR (24) HOUR PHYSICIAN COVERAGE --- HMO shall ensure that a physician Participating Provider or physician employed by HMO is available twenty-four (24) hours a day, seven (7) days a week for timely authorization including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, HMO shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies.

5.2 URGENT CARE SERVICES --- HMO shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- HMO shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment, and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. HMO shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. HMO's failure to perform at or in excess of minimum performance requirements shall subject HMO to sanctions in accordance with this Contract and CalOptima Policies. HMO shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- HMO shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults

shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 HOSPITAL GEOGRAPHIC DISTRIBUTION --- HMO agrees that each hospital participating in the HMO, shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services - HMO shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. HMO shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – HMO shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. HMO shall arrange for the provision of specialty services from specialists outside the network if unavailable within HMO's network, when determined medically necessary.

5.6.3 Preventive Covered Services - HMO shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services - HMO shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. HMO shall cover and ensure the provision of all Medically Necessary services for pregnant Members. HMO shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement - HMO shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization– within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS.

5.7 OFFICE WAITING TIMES --- HMO shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. HMO's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject HMO to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- HMO shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. HMO's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. HMO's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- HMO shall give Members thirty (30) calendar days' notice if their PCP withdraws from HMO. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by HMO. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within HMO for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- HMO shall offer each Member the opportunity to choose a PCP affiliated with the HMO. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When HMO receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, HMO shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in HMO. HMO shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12. PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, HMO shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, HMO shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-physician Medical Practitioners are included in HMO's Network, each individual Non-physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - HMO shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or

5.13.2.2 Four (4) physician assistants; or

5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- HMO shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- HMO shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). HMO shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles from Member's place of residence.

5.16 PHYSICAL ACCESS --- HMO's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- HMO shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.
5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members.

ARTICLE 6
Obligations of HMO – Clinical Quality

6.1 LICENSURE --- HMO shall ensure that every physician providing Covered Services and employed or engaged by HMO or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- HMO shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;

6.2.2 Refer Members to appropriate HEP, based on the Member's needs;

6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,

6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- HMO shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- HMO shall participate and cooperate in CalOptima's Quality Improvement Program. HMO shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set

(HEDIS)). HMO shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of HMO or a multi-disciplinary QI Committee designated by the Board of Directors of HMO shall oversee the QI Program conducted by HMO. This committee shall be separate from the Utilization Review committee (though Members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from HMO. The QI Committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 The HMO's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 HMO shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or the HMO; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the HMO's QI Program shall be established by the HMO's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's

QI Program. HMO shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 HMO shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, HMO shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 The HMO shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 HMO shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- HMO shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 HMO shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 HMO Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review HMO's Case Management Services program to determine compliance with Case Management Services standards. HMO shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 HMO Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, HMO shall assure that HMO possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF HMO UPON TERMINATION OF CONTRACTED PROVIDERS --- HMO shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site and assisting them in selecting a new PCP or PCP site. HMO shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a new PCP or PCP site. HMO shall notify

Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. HMO shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or HMO decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with HMO, but the rest of the group continues its contract with HMO, then HMO shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2^{nd}) or third (3^{rd}) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, HMO shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by HMO's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, HMO

shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- HMO shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment, HMO shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. HMO's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. HMO must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, HMO may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated HMO shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated HMO shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- HMO shall credential CCS Providers in accordance with the existing credentialing requirements along

with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, HMO shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 HMO shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, HMO shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 HMO shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by HMO, HMO remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program,

HMO shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), HMO must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, HMO may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, HMO must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts HMO's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by HMO and the CCS Provider.

6.7.5.2.3 HMO confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to HMO, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, HMO and the Member's prescribing CCS

Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, HMO shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, HMO shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. HMO shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 HMO shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, HMO shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 HMO shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, HMO shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, HMO shall send a written notice 60 days prior to the end of the authorized continuity of care

period. The notice shall explain the right to petition HMO for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if HMO denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 HMO must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- HMO acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to HMO. HMO shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 HMO shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 HMO shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for

Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. HMO shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. HMO shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 HMO shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 If applicable, Quarterly Summaries and copies of facility site reviews performed for PCPs.

6.9 BOARD CERTIFICATION --- HMO shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 HMO shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any

Covered Services furnished to Members. HMO shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 HMO acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with HMO to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW --- HMO shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. HMO shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- HMO shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 HMO shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the HMO.

6.11.4 HMO shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 HMO shall be responsible for coordinating care of certain services including:

6.11.8.1 HMO's Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 HMO shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 HMO shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 HMO shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 HMO shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 HMO shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. HMO shall develop referral and prior authorization policies and procedures to implement the above requirements. HMO shall submit these policies to CalOptima for review and approval;

6.11.8.9 HMO shall provide outpatient mental health services within the PCP's scope of practice. HMO shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. HMO shall retain

financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. HMO shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.

6.11.8.11 For Outpatient Mental Health Services, HMO shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, HMO shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, HMO shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services,

including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 HMO shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use it as the HMO is able for the purpose of Member care coordination.

6.12 VACCINES --- HMOs shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with HMO's immunization policy. CalOptima shall not reimburse HMO for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 HMO may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- HMO agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF HMO FOR SPD --- HMO shall provide the following for SPD Members:

6.15.1 HMO shall participate in the Community Liaison Program according to the guidelines and policies CalOptima promulgates to operate the program and as set forth in this Contract and CalOptima Policies;

6.15.2 HMO shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 HMO shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. HMO shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 HMO shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) HMO determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period;

6.15.5 HMO or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. HMO shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, HMO shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the HMO;

6.15.6 HMO shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. HMO shall provide to all SPD Members upon enrollment HMO and at any time thereafter, upon the SPD Member's request a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment in the HMO of an SPD Member, HMO shall complete a plan of care pursuant to CalOptima

Policies. HMO shall update this plan as appropriate and/or annually. HMO shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies, , HMO shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 HMO shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 HMO shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If HMO's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, HMO must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. HMO acknowledges that out-of-network providers must coordinate with HMO with respect to payment, and HMO shall ensure that such out-of-network providers understand this requirement. HMO must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. HMO shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, HMO shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept HMO or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, HMO shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 HMO and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions.

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members. The Profile shall include the compliance parameters required to receive PCC supplemental capitation.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.15 HMOs shall be eligible to receive the supplemental PCC capitation as defined in Attachment E if HMO remains in good standing with CalOptima which shall include but not limited to the following:

6.15.15.1 No sanctions in place for the Medi-Cal program;
6.15.15.2 Resolution satisfactory to CalOptima of all identified Medi-Cal Program compliance deficiencies from the preceding calendar quarter;
6.15.15.3 Execution of all previous amendments; and
6.15.15.4 Other requirements contained in CalOptima Policy, as applicable.

6.15.16 During any period in which CalOptima provides funding for the PCC program, and written notice that the program is active, HMO shall provide PCC services in accordance with the following:

6.15.16.1 HMO shall employ PCCs, and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. HMO shall staff one PCC per six hundred (600) CCS or SPD Members assigned to HMO. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. HMO shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.16.2 CalOptima shall provide HMO with Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to HMO thirty (30) days prior to the effective date of such change. If HMO is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30) day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to HMO and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- HMO shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. HMO shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- HMO shall provide, at its sole cost and expense second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- HMO shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- HMO shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. HMO shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- HMO shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. HMO shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, HMO and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of HMO – Reporting

7.1 DATA REPORTING REQUIREMENTS --- HMO shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. HMO shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- HMO shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's regulators as provided in this Contract and in CalOptima Policies. HMO shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; HMO shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that HMO is reporting to CalOptima less than all professional and facility encounters in the CalOptima required format and timelines. HMO shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- HMO agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred-twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Members. HMO shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If HMO is required to file monthly Financial Statements with the DMHC, HMO shall simultaneously file monthly Financial Statements with DHCS. HMO shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. HMO shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- HMO shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting HMO's provider network.

7.6 HMO ORGANIZATION PROFILE --- HMO shall report in compliance with CalOptima Policies, a profile of the HMO's organization, including, but not limited to, HMO's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- HMO shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by HMO, HMO shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, HMO shall provide copies of any Subcontract entered into or amended for purposes of fulfilling HMO's obligations under this Contract.

7.8 DISCLOSURE --- HMO and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of HMO's or Subcontractor's financial records related to HMO's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that HMO, or any of its officers, employees, agents,

or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – HMO shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meets its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, HMO shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by HMO to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the HMO's letterhead signed by the HMO's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of HMO – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that HMO shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of HMO at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which HMO received Capitation Payment and termination occurred, HMO shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the HMO shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 HMO agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by HMO.

8.3 TERMINATION PLANS --- HMO shall have a plan for the orderly termination of services under this Contract. HMO shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- HMO acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and HMO shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. HMO acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 NOTICE TO THE DEPARTMENT OF MANAGED HEALTH CARE -- In addition, HMO shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with HMO, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to HMO on or about the fifteenth (15^{th}) of the month for enrolled Member.

Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with HMO.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from HMO an amount equal to twenty-five percent (25%) of the monthly Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of HMO's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the HMO. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and HMO shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- HMO has an obligation to report any overpayment identified by HMO, and to repay such overpayment to CalOptima within sixty (60) days of such identification by HMO, or of receipt of notice of an overpayment identified by CalOptima. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO, after giving HMO notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from HMO to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by HMO to a Member. Capitation payments made in relation to a Member for a period after the Member was deceased.

9.4.4 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to HMO's capitation

9.4.5 Payments made by CalOptima that are the financial responsibility of HMO.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of HMO paid by CalOptima against any funds owed to HMO by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or HMO additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay HMO any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by HMO.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to HMO is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with HMO and enrolled in

CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY – Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 Not Applicable to this Contract.

10.2 COMPREHENSIVE HMO AUDIT --- CalOptima shall conduct and HMO shall agree to a full comprehensive compliance audit to be conducted at HMO administrative offices and/or Facilities annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the HMO audit in writing to the HMO. HMO may rebut and dispute audit findings pursuant to CalOptima Policies. HMO is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. HMO acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from HMO.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each HMO's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the HMO accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current MOUs entered into by CalOptima that are binding on HMO. Copies of current MOUs entered into by CalOptima that are binding on HMO may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for HMO interpretation of MOUs entered into by CalOptima that are binding on HMO. Interpretation of MOUs will identify duties, obligation and responsibilities of HMO.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- HMO acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to HMO, information and data relating to the performance of HMO that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including HMO, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. HMO complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to HMO the financial risk assumed under the Contract by providing to HMO the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician,

institutional, ancillary, and pharmacy) which will be allocated to HMO, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to HMO the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to HMO sufficient details to allow HMO to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all HMO, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF HMO TERMINATION PLANS --- CalOptima shall review and approve HMO termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release HMO's capitation withhold to HMO upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by HMO of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply HMO's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 Not Applicable to this Contract.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- HMO may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the HMO ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 MEMBER LIAISON PROGRAM (MLP) --- HMO shall establish and maintain support for the Member Liaison Program, including but not limited to:

12.2.1 Providing SPD Members and their caregivers with assistance to navigate the Medi-Cal managed care system;

12.2.2 Coordinating the range of Covered Services needed by SPD Members and assisting SPD Members in understanding and utilizing HMO's referral process;

12.2.3 Ensuring SPD Members receive appropriate and timely referrals;

12.2.4 Identifying barriers faced by SPD Members and integrating recommendations into the delivery system to improve access;

12.2.5 Keeping HMO and Participating Providers educated and sensitive to the needs of persons with disabilities;

12.2.6 Assisting PCPs to fully understand individual SPD Members' needs and provide physicians with access to the many community based resources available;

12.2.7 Providing feedback to CalOptima regarding necessary program modifications/enhancements;

12.2.8 Providing access to SPD Members information necessary for coordination of Covered Services across all HMO departments;

12.2.9 Assisting in the promotion, outreach and community awareness of the MLP.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If HMO fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (vii) failure to ensure that all Minimum Standards are met; (viii) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (ix) not having the required amounts and types of financial reserves; (x) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xi) failure to meet Medical Loss Ratio requirements; (xii) failure to meet minimum enrollment requirements; (xiii) failure to meet quality and/or performance requirements; (xiv) failure to comply with organization structure requirements; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted

within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the HMO's Capitation Payment.

13.1.2.2 HMO may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause - Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. HMO may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. HMO shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, HMO shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of HMO.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the HMO in the event that membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of HMO membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should HMO fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should HMO fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to HMO that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR HMO ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should HMO fail to comply with requirements for HMO's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR HMO INSOLVENCY --- If HMO becomes insolvent, HMO shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against HMO or a principal Subcontractor, HMO shall assure that all HMO's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any

and all withheld amounts as necessary to ensure that all HMO obligations have been met.

13.11 TERMINATION BY HMO FOR CAUSE --- Provided that HMO is not in default hereunder, HMO may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to HMO under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to HMO any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW --- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify HMO in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and HMO shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO HMO --- CalOptima may establish key performance measures of HMO to set minimum contract performance thresholds and/or pay financial incentives to Health Network. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against HMO, terminate this Contract, and establish Capitation Rates and other payments to HMO.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- HMO agrees as follows:

13.14.1 CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members, provided that the imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that HMO Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that HMO terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such

Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, HMO shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event HMO elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION --- Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF HMO --- CalOptima and HMO agree that HMO and any agents or employees of HMO, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. HMO shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California,

unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY--- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION --- HMO agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO or Subcontractor; (iii) the merger, reorganization, or consolidation of HMO or Subcontractor with another entity with respect to which HMO or Subcontractor is not the surviving entity; and/or (iv) a change in the management of HMO or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of HMO or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this

Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the HMO agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the HMO certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the HMO is unable to certify to any of the statements in this certification, the HMO shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the HMO knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. HMO further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION -

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure in the form set forth in Attachment F, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: HMO

_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- HMO shall ensure that HMO and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act

(California Government Code section 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
SIGNATURES

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE _____ THROUGH _____.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Contract:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	-See Transportation-		
Amniocentesis	X		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	X		
Facility component		X	
Birth Control	-See Family Planning-		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
CBAS			**CalOptima (Claims)**
CHDP	-See Pediatric Preventative Services-		

	Physician	Hospital Budget	Other
Chemotherapy			
Professional component	**X**		
Outpatient Facility component		**X**	
Medication		**-See Medication-**	
Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services (related to dental services)			
Professional component (Other than provided by Dentist)	**X**		
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component		**X**	
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**		
Customer Wheelchair Assessments through MTP			**OC HCA/ State**
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services[2]			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)	**X**		
Medical Nutrition Services	**X**		
Occupational Therapy	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	**X**		
Mental Health – Specialty Outpatient			**OC HCA/ State**

	Physician	Hospital Budget	Other
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	**X**		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables	***- See Medications -***		
Immunizations	***- See Preventive Services -***		

	Physician	Hospital Budget	Other
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**

	Physician	Hospital Budget	Other
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission		**X**	
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Partial Hospitalization Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		

	Physician	Hospital Budget	Other
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Dietetic Counseling/Medical Nutrition Therapy/ Health Education	**X**		
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Nutrition Products	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		
Outpatient Diagnostic Services	***-See Diagnostic Services (Outpatient) -***		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		

	Physician	Hospital Budget	Other
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Immunizations (19 years and over)			
Vaccine (inclusive of Medi-Cal administration fee)	**X**		
Adult Periodic Health Exams	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	***- See Diagnostic Services -***		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	***- See Long Term Care Services -***		
Short stay	***- See Hospitalization -***		
Speech Therapy	***- See Rehabilitation -***		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			
[2] ***Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT C
Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective July 1, 2019

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Family/Poverty/Child	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Low Income Children Program (formerly Healthy Families)	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Adult	All Ages Both			
Aged	All Ages, Both			
Disabled	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
ESRD - Family	All ages, Both			
ESRD - Poverty	All ages, Both			
ESRD - Child	All ages, Both			
ESRD - Adult	All ages, Both			

ESRD - Aged	All ages, Both			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD - Disabled	All ages, Both			
ESRD - MCX	All ages, Both			
ESRD - MSI	All ages, Both			
AIDS - Family	All ages, Both			
AIDS - Poverty	All ages, Both			
AIDS - Child	All ages, Both			
AIDS - Adult	All ages, Both			
AIDS - Aged	All ages, Both			
AIDS - Disabled	All ages, Both			
AIDS - MCX	All ages, Both			
AIDS - MSI	All ages, Both			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Whole Child Model Base Capitation Rates

The following Whole Child Model payment provisions are effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program.

The following base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

	Hospital	Physician	Total Capitation
Whole Child Model			

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Funding for PCC

In addition to those amounts described above, HMO shall receive _____per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups. CCS member is identified by their CCS Eligible condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Members with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-1
Capitation Rates for Adult Expansion Members

Effective July 1, 2019 through June 30, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code	Age & Gender	Base Cap Rate		
Category	**Category**	**Hospital**	**Physician**	**Total**
Expansion (MCX)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
Expansion (MSI)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least [redacted] of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment F-1 is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

- Payment rates shall be as follows:
  - Physician payment $
  - Hospital payment $

Funding for PCC – Effective October 1, 2018

In addition to those amounts described above, HMO shall receive [redacted] per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups and CCS member is identified by their CCS Eligible Condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-2
DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to HMO which HMO agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay HMO an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with HMO to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. HMO shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. HMO shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by HMO to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by HMO for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by HMO, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse HMO for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by HMO more than one year after the date of service.

4. HMO shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by HMO.

5. On a monthly basis, HMO must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by HMO or by HMO's delegated entities and subcontractors at HMO's direction. Reports shall include all supplemental Prop 56 payments made during the month. HMO must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. HMO, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay HMO a [redacted] administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by HMO to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a [redacted] administrative component based on confirmed Prop 56 increase payments and shall be remitted to the HMO.

7. CalOptima's obligation to pay HMO any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to HMO if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. HMO shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 201-7 and after.

9. HMO acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, HMO shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. HMO agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, HMO shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to HMO, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018

HMO shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to HMO prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019

HMO shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to HMO. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by HMO no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT F-1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify: _____

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

Provider name
Medi-Cal Health Network Contract - HMO
Effective Date:

Back to Agenda Back to Item

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

AMENDMENT V TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT V TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2020, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure and revise the capitation rates.

NOW, THEREFORE, the parties agree as follows:

1. Section 2.7.18. of the Contract, and any references thereto, shall be renumbered as Section 2.7.19, and new Section 2.7.18 shall be added to the Contract as follows:

   "2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and HMO shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-2 and E-3, by HMO to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to HMO."

2. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

   "15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2021."

3. ATTACHMENT E shall be deleted and replaced with the attached ATTACHMENT E- AMENDMENT V "Capitation Rates".

4. ATTACHMENT E-1 shall be deleted and replaced with the attached ATTACHMENT E- 1 - AMENDMENT V "Capitation Rates for Adult Expansion Members".

5. ATTACHMENT E-2 "Distribution of Proposition 56 Funding" and Addendums to this Attachment shall be deleted and replaced with the attached ATTACHMENT E-2 – AMENDMENT V, "Distribution of Proposition 56 Funding".

6. ATTACHMENT E-3 “Distribution of GEMT QAF Funding” shall be deleted and replaced with the attached ATTACHMENT E-3 – AMENDMENT V, “Distribution of GEMT QAF Funding”.

7. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT V

Capitation Rates

Effective July 1, 2020

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, HMO shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future

PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-1 – AMENDMENT V

Capitation Rates for Adult Expansion Members

Effective July 1, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to HMO.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require HMO to remit the portion of the difference attributed to HMO.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to HMO.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Expansion	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

For services rendered to Adult Expansion Members, HMO shall reimburse Specialist Physicians, in the aggregate, at least [redacted]% of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, HMO shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible Condition as determined by the local WCM Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Member's with a WCM Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-2 -AMENDMENT V

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to HMO which HMO agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay HMO an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with HMO to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    b. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    c. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. HMO shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. HMO shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by HMO to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by HMO for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by HMO, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse HMO for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by HMO more than one year after the date of service.

4. HMO shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by HMO.

5. On a monthly basis, HMO must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by HMO or by HMO's delegated entities and subcontractors at HMO's direction. Reports shall include all supplemental Prop 56 payments made during the month. HMO must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. HMO, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay HMO a [redacted] administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by HMO to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a [redacted]% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the HMO.

7. CalOptima's obligation to pay HMO any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to HMO if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. HMO shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. HMO acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, HMO shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. HMO agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, HMO shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to HMO, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

15. Notwithstanding other provisions of this Attachment E-2, effective July 1, 2020, CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

HMO shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to HMO prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

HMO shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to HMO. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by HMO no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT E-3 – AMENDMENT V
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and HMO, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. HMO must reimburse Eligible Non-Contracted Providers a differential totaling up to [redacted] that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to HMO, and HMO agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay HMO an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. "Eligible Non-Contracted Provider" shall mean a Provider who is not contracted with HMO to provide GEMT services or a Provider who is contracted with HMO for transportation services, but not contracted with HMO to provide GEMT services to CalOptima Medi-Cal members.

    b. "Qualifying Services" shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. HMO shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to [redacted] for Qualifying Services furnished by Eligible Non-Contracted Providers. HMO is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the HMO within one year after the date of service.

3. HMO shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. HMO is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a [redacted]% administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to HMO based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. HMO shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to HMO by means of a Notice to this Contract.

10. Notwithstanding other provisions of this Attachment E-3, effective July 1, 2020, CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program pursuant to Section 2.7.18 of the Contract.

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO wish to enter into this amendment to revise the Division of Financial Responsibilities, revise the Termination for Convenience provision as well as modify language as appropriate to align with all Health Care Services contracts.

NOW, THEREFORE, the parties agree as follows:

1. Section 1.16, "CalOptima Regulators", shall be deleted in its entirety and replaced with the following:

   "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforce applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, HMO, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Health Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

2. Section 1.22, "Community Liaison" or "CL", shall be deleted and intentionally left blank.

3. Section 1.23, "Community Liaison Program" or "CLP", shall be deleted and intentionally left blank.

4. Section 1.55, "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)", shall be deleted in its entirety and replaced with the following:

   "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

5. Section 1.64, "Memorandum/Memoranda of Understanding" or "MOU", shall be deleted in its entirety and replaced with the following:

   "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements,

including but not limited to the Coordination and Provision of Public Health Care Services Contract.

6. Section 1.83, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)", shall be deleted in its entirety and replaced with the following:

"Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care HMO to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol."

7. Section 1.94, "Subcontract", shall be deleted in its entirety and replaced with the following:

"Subcontract" means a written agreement entered into by the HMO with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

8. Section 1.95, "Subcontractor", shall be deleted in its entirety and replaced with the following:

"Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with HMO. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with HMO to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract."

9. Section 2.3.2 shall be deleted in its entirety and replaced with the following:

"Commercial General Liability/Commercial Automobile Liability:
HMO shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on HMO's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract."

10. Section 2.3.8 shall be deleted in its entirety and replaced with the following:

"Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by HMO shall be provided to CalOptima prior to execution of the Contract and annually thereafter. HMO shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request."

11. Section 2.7.12, "Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments", shall be deleted in its entirety and replaced with the following:

"Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in HMO's provider network, HMO shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy."

12. Section 2.7.13, "Family Planning Provider Payments", shall be deleted in its entirety and replaced with the following:

"Family Planning Provider Payments - HMO shall reimburse non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy."

13. Section 2.7.14, "Sexually Transmitted Disease Treatment Payments", shall be deleted in its entirety and replaced with the following:

"Sexually Transmitted Disease Treatment Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. HMO may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to HMO along with billing information."

14. Section 2.7.15, "HIV Testing and Counseling Payments", shall be deleted in its entirety and replaced with the following:

"HIV Testing and Counseling Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to HMO."

15. Section 3.4, "CALOPTIMA LOGO", shall be deleted in its entirety and replaced with the following:

"CALOPTIMA LOGO --- HMO shall not display the CalOptima logo on any of HMO's written communication to Members without prior written approval by CalOptima."

16. Section 3.9, "SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"SUBCONTRACTS --- HMO may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. HMO is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. HMO is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. HMO shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI and CMS requirements for reporting information about Offshore Subcontracts. HMO shall annually

complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, HMO shall require all Subcontracts contain the following:"

17. Section 3.9.2 shall be deleted in its entirety and replaced with the following:

"An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;"

18. Section 3.9.7 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;"

19. Section 3.9.8 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;"

20. Section 3.9.10 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;"

21. Section 3.9.12 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;"

22. Section 3.9.20 shall be deleted in its entirety and replaced with the following:

"An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if HMO delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement);"

23. Section 3.9.25 shall be deleted in its entirety and replaced with the following:

"An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and"

24. Section 3.9.26 shall be added as follows:

"Subcontractor's agreement to provide HMO with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request."

25. Section 3.17, "MEDICAL AND ADMINISTRATIVE RECORDS", shall be deleted in its entirety and replaced with the following:

"MEDICAL AND ADMINISTRATIVE RECORDS --- HMO shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). HMO shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site."

26. Section 3.19.1 shall be deleted in its entirety and replaced with the following:

"Through the end of the records retention period specified in Section 3.18, HMO shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the HMO's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years."

27. Section 3.24, "FRAUD AND ABUSE REPORTING", shall be deleted in its entirety and replaced with the following:

"FRAUD AND ABUSE REPORTING --- HMO shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or HMO's employees, within five (5) working days of the date when HMO first becomes aware of or is on notice of such activity."

28. Section 3.24.2 shall be deleted in its entirety and replaced with the following:

"HMO shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program."

29. Section 3.28, "COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- HMO shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. HMO's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations."

30. Section 3.30, "COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s))", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- HMO agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. HMO agrees to require Subcontractors to comply with applicable requirements of such MOUs."

31. Section 3.42, "OBLIGATIONS UNDER PRIOR CONTRACT", shall be deleted in its entirety and replaced with the following:

"OBLIGATIONS UNDER PRIOR CONTRACT --- HMO acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). HMO shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between HMO and CalOptima pursuant to which HMO agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members."

32. Section 3.45, "HMO SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"HMO SUBCONTRACTS --- In addition to Section 3.9 of this Contract, HMO shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. HMO shall ensure that all Subcontracts are in writing and require that the HMO and its Subcontractors:"

33. Section 4.2, "EMERGENCY CARE", shall be deleted in its entirety and replaced with the following:

"EMERGENCY CARE --- HMO shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). HMO is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week."

34. Section 4.7, "ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES", shall be deleted in its entirety and replaced with the following:

"ALCOHOL MISUSE SCREENING AND COUNSELING --- HMO shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC."

35. Section 4.1.9.2 shall be deleted in its entirety and replaced with the following:

"That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the HMO and Participating Providers or Subcontractors;"

36. Section 5.6.8 shall be deleted in its entirety and replaced with the following:

"In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements."

37. Section 5.15, "SPECIALIST GEOGRAPHIC DISTRIBUTION", shall be deleted in its entirety and replaced with the following:

"SPECIALIST GEOGRAPHIC DISTRIBUTION --- HMO shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). HMO shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence."

38. Section 6.4, "QUALITY IMPROVEMENT PROGRAM", shall be deleted in its entirety and replaced with the following:

"QUALITY IMPROVEMENT PROGRAM --- HMO shall participate and cooperate in CalOptima's Quality Improvement Program. HMO shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). HMO shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. HMO shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:"

39. Section 6.8.3.3 shall be deleted in its entirety and replaced with the following:

"An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS."

40. Section 6.15.1 shall be deleted and intentionally left blank.

41. Section 6.15.13 shall be deleted in its entirety and replaced with the following:

"HMO and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by HMO pursuant to DHCS requirements and CalOptima Policies."

42. Section 10.2, "COMPREHENSIVE HMO AUDIT", shall be deleted in its entirety and replaced with the following:

"COMPREHENSIVE HMO AUDIT --- CalOptima shall conduct and HMO shall agree to a full comprehensive compliance audit to be conducted at HMO administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the HMO audit in writing to the HMO. HMO may rebut and dispute audit findings pursuant to CalOptima Policies. HMO is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. HMO acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from HMO."

43. Section 10.7, "MOU AVAILABILITY", shall be deleted in its entirety and replaced with the following:

"MOU AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current MOUs entered into by CalOptima that are binding on HMO within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on HMO may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website."

44. Section 10.10, "PROVIDER COMPLAINT SYSTEM", shall be deleted in its entirety and replaced with the following:

"PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and HMO shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. HMO complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system."

45. Section 12.2, "MEMBER LIAISON PROGRAM (MLP)", shall be deleted and intentionally left blank.

46. Section 13.1, "SANCTIONS AND TERMINATIONS FOR CAUSE," shall be deleted in its entirety and replaced with the following:

"SANCTIONS AND TERMINATIONS FOR CAUSE --- If HMO fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (vii) failure to ensure that all Minimum Standards are met; (viii) failure to enforce claims payment prohibitions on providers who are denied

the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (ix) not having the required amounts and types of financial reserves; (x) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xi) failure to meet Medical Loss Ratio requirements; (xii) failure to meet minimum enrollment requirements; (xiii) failure to meet quality and/or performance requirements; (xiv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:"

47. Section 13.9, "TERMINATION FOR CONVENIENCE", shall be deleted in its entirety and replaced with the following:

"TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination."

48. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment VI.

49. Attachment E, "Capitation Rates", shall be deleted and replaced with the attached Attachment E – Amendment VI.

50. Attachment E-5, "Funding for Health Homes Program (HHP)" shall be deleted in its entirety and replaced with the attached Attachment E-5 – Amendment VI.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A – AMENDMENT VI
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)			**X**		
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
All other Medical Supplies[1]	**X**				
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		

	Physician		Hospital		Other
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)'s***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				

	Physician		Hospital		Other
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				

	Physician		Hospital		Other
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***

	Physician		Hospital		Other
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation *					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
** CCS specific services are paid per Article 9.*					
[1] Services are the responsibility of MTP if provided under the MTP program.					
[2] Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.					

ATTACHMENT E – AMENDMENT VI

Capitation Rates

Effective January 1, 2021

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, HMO shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

Attachment E-5 – Amendment VI

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to HMO for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

- Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
- Member is enrolled in the HHP;
- Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the HMO, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the HMO;
- The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
- If applicable, the HMO paid the provider for the HHP core services; and
- The HMO authorized such HHP core services.

[redacted] (January – June 2020)
(July – December 2020)
(January – December 2021)

2. Engagement Activities Supplemental Capitation Payment

2.1 Subject to Section 2.2 of this Attachment E-5, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

- Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
- The HMO conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
- Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
- If applicable, the HMO authorized and paid the provider for such engagement

[redacted] (January – June 2020)
(July – December 2020)
(January – December 2021)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. HMO shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15^{th}) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT I TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT I TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of October 1, 2019 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO wish to enter into this amendment to restate the Division of Financial Responsibilities and Formulary Medical Supplies, provide the requirements for the distribution of Ground Emergency Medical Transportation (GEMT)/QAF supplemental payment and provide information and requirements related to supplemental payments for certain home health agency services.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility" shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I.

2. Attachment C, "Formulary Medical Supplies" shall be deleted in its entirety and replaced with the attached Attachment C – Amendment I.

3. Attachment E-3, "Distribution of GEMT QAF Funding", shall be added to the Contract and is attached hereto.

4. Attachment E-4, "Supplemental Payment for Home Health Agency Services", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services
Amendment I

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party				
	Physician		**Hospital**		**Other**
Acupuncture	**X**				
Allergy Testing & Treatment					
Testing	**X**				
Serum	**X**				
Immunotherapy injections	**X**				
Ambulance	***- See Transportation -***				
Amniocentesis	**X**				
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)					
Professional component	**X**				
Facility component			**X**		
Birth Control	***- See Family Planning -***				
Blood and Blood Products					
From blood bank			**X**		
Transfusions, blood and blood components			**X**		
Autologous Transfusion (including collection of)			**X**		
Outpatient Transfusion, Blood and Blood Components			**X**		
Breast Implant (post-mastectomy) or Removal (medically necessary only)					
Professional component	**X**				
Facility component			**X**		
Breast Reconstructive Surgery (after cancer)					
Professional component	**X**				
Facility component			**X**		
CBAS					***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***				
Chemotherapy					
Professional Component	**X**				
Outpatient Facility Component			**X**		
Medication	***- See Medication -***				

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)	**X**				
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				

	Physician		Hospital		Other
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				

	Physician		Hospital		Other
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				

	Physician		Hospital		Other
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				

	Physician		Hospital		Other
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component	**X**				
Outpatient facility component	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***

	Physician		Hospital		Other
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***					
[2] ***Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.***					

ATTACHMENT C

Amendment I

Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

Respiratory Items

- Inhaler Assist Devices
- Nasal Aspirator
- Peak Flow Meters, Non-Electric

Contraceptive Items

- Condoms
- Diaphragms

Diabetic Supplies

- Blood Glucose Monitors (excludes Continuous Glucose Monitors which are covered as DME)
- Insulin Syringes
- Lancets
- Lancet Auto Injectors
- Blood Glucose Test Strips
- Urine Test Strips
- Alcohol Pads

ATTACHMENT E-3
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and HMO, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. HMO must reimburse Eligible Non-Contracted Providers a differential totaling up to $XX that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to HMO, and HMO agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay HMO an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. “Eligible Non-Contracted Provider” shall mean a Provider who is not contracted with HMO to provide GEMT services or a Provider who is contracted with HMO for transportation services, but not contracted with HMO to provide GEMT services to CalOptima Medi-Cal members.

    b. “Qualifying Services” shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. HMO shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to $xxx.00 for Qualifying Services furnished by Eligible Non-Contracted Providers. HMO is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the HMO within one year after the date of service.

3. HMO shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. HMO is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse

the GEMT QAF Program payment adjustments separate from the capitation payments, plus a x% administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to HMO based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. HMO shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to HMO by means of a Notice to this Contract.

ATTACHMENT E-4

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the [redacted] payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by [redacted] effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, HMO will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the HMOs' reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

AMENDMENT II TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT II TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____. ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Health Homes Program.

NOW, THEREFORE, the parties agree as follows:

1. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

"1.102 Community-Based Care Management Entity (CB-CME) means HMO when providing Health Homes Program (HHP) services to HHP Members pursuant to this Contract.

1.103 Health Homes Program or "HHP" means all of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for provision of HHP services that provide supplemental services to HHP eligible and enrolled Members by coordinating and integrating the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed for chronic conditions.

1.104 HHP Member who is HHP enrolled, and continuously participating in the HHP and assigned to the HMO.

1.105 HHP Multi-Disciplinary Care Team means a team of staff employed or contracted by the HMO, as a CB-CME, that provides HHP services to HHP Members."

2. Section 6.22 shall be added as follows:

"6.22 HEALTH HOMES PROGRAM ---

6.22.1 HMO shall begin participating in CalOptima Health Homes Program, as follows: (i) Effective January 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible chronic physical conditions and substance use disorders; and (ii) Effective July 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible serious mental illness.

6.22.2 HMO shall be responsible for providing and coordinating HHP services as one of the designated Community-Based Care Management Entities (CB-CMEs). HMO, as a CB-CME, shall ensure its systems and infrastructure are in place to provide HHP services to HHP Members. HMO, as a CB-CME, shall satisfy the CB-CME qualification standards as defined by DHCS and

CalOptima Policy, and CB-CME certification requirements as described in DHCS HHP Program Guide.

6.22.3 HMO shall comply with all State and federal requirements related to HHP and HHP requirements determined by DHCS, including the All Plan Letter related to Health Homes Program requirements and the HHP Program Guide. HMO, as a CB-CME, shall implement CalOptima Health Homes Program in accordance with this Contract and CalOptima Policies. HMO shall ensure that HMO staff who will be delivering HHP services complete training required by CalOptima and DHCS prior to participating in the administrative of the HHP.

6.22.4 HMO, as a CB-CME, shall be responsible for coordinating care with HHP Members, Providers, and other agencies as appropriate. HMO shall provide the following six (6) core HHP service categories for HHP Members: (i) Comprehensive care management; (ii) Care coordination; (iii) Health promotion; (iv) Comprehensive transitional care; (v) Individual and family support services; and (vi) Referral to community and social supports.

6.22.5 HMO shall maintain an aggregate minimum care coordinator ratio as defined by DHCS. HMO shall ensure the establishment of HHP Multi-Disciplinary Care Teams to provide HHP services, as set forth in CalOptima Policy GG.1331.

6.22.6 HMO shall ensure availability of Providers with experience working with people who are chronically homeless, pursuant to Welfare & Institutions Code section 14127.31(d)(1)(B).

6.22.7 HMO shall establish, as necessary, contractual relationships with organizations to provide HHP services (including but not limited to office visit accompaniment, housing navigator, individual housing transition services, and individual housing and tenancy sustaining services), and contractual or non-contractual relationships to provide linkages to community and social support services. Regardless of the subcontracting arrangement, HMO shall retain overall responsibility for all CB-CME duties and responsibilities set forth in this Contract and CalOptima Policies.

6.22.8 HMO shall conduct outreach and engagement activities for HHP-eligible Members who are not enrolled in HHP. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent to HHP participation may be oral or in writing and shall be documented by the HMO's Customer Service staff or HHP Multidisciplinary Care Team staff prior to the Member's participation in HHP. CalOptima and HMO will coordinate to ensure that Members who meet exclusionary criteria are excluded or disenrolled from the HHP pursuant to the HHP Program Guide and CalOptima Policy GG.1350.

6.22. 9 HMO, as a CB-CME, shall complete a health needs assessment (HNA) and develop a health action plan (HAP) for each HHP Member. HMO shall ensure case conferences are conducted by the HHP Multidisciplinary Care Team and the HHP Member's HNA and HAP are updated as necessary.

6.22.10 HMO may use HHP funding to make payments to HHP Members' network Providers who are not included formally on the HMO's HHP Multi-Disciplinary Care Team, but who are responsible for coordinating with the HMO's HHP care coordinator to conduct case conferences and to provide input to the health action plan (HAP).

6.22.11 In addition to other provisions of this Contract, HMO shall comply with CalOptima Policies GG.1331, GG.1350 and FF.4001 related to CB-CME duties and responsibilities, including engagement activities, the DHCS HHP Program Guide, and CB-CME requirements set forth in Welfare & Institutions Code, section 14127.3(d)(1).

6.22.12 HMO's Agent's Qualifications. HMO shall verify the qualifications of all agents (including HMO staff) providing services under this Contract consistent with the services to be provided under the Health Homes Program. In addition, for agents that enter into Members' homes or have face-to-face contact with Members, HMO shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. HMO shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

6.22.13 HHP Data Sharing. CalOptima and HMO agree to exchange available information and data as required by DHCS for the HHP, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of HHP Members. CalOptima and HMO shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements, and other federal and California state laws and regulations, including applying the minimum necessary standard, when applicable. Further, HMO shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an HHP Member's valid authorization for release of health information and a legal exception does not apply, HMO may not release such information without the HHP Member's valid authorization.

6.22.14 HHP Data Reporting. HMO shall submit to CalOptima complete, accurate, reasonable and timely data reports in the manner and form acceptable to CalOptima in order for CalOptima to meet its data reporting requirements to DHCS for the HHP."

3. Attachment E-5, "Funding for Health Homes Program", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-5

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to HMO for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

   1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
   - Member is enrolled in the HHP;
   - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the HMO, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the HMO;
   - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
   - If applicable, the HMO paid the provider for the HHP core services; and
   - The HMO authorized such HHP core services.

   [redacted] PMPM (January – June 2020)
   PMPM (July – December 2020)

2. Engagement Activities Supplemental Capitation Payment

   2.1 Subject to Section 2.2 of this Attachment E-5, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
   - The HMO conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
   - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
   - If applicable, the HMO authorized and paid the provider for such engagement

   [redacted] PMPM (January – June 2020)
   PMPM (July – December 2020)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. HMO shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15^{th}) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT III TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT III TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract for the allocation and distribution of Intergovernmental Transfer (IGT) 6 and 7 Funds for Whole-Child Model (WCM) Startup Expenses incurred by HMO. IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 1–7 funds are designated for enhanced/additional benefits for Medi-Cal beneficiaries.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-6, "Whole-Child Model (WCM) Start-up Expenses Reimbursement", shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____. have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-6

Whole-Child Model (WCM) Program Start-up Expense Reimbursement

This attachment sets forth the program of additional compensation for Whole Child Model (WCM) start-up expenses, as authorized by the CalOptima Board of Directors at its December 5, 2019, meeting.

A. Reimbursement Available. There are two parts of the expense related reimbursement payments available to HMO.

1. Flat Rate: HMO shall receive a one-time payment amount of $xx; AND,

2. Variable Rate: If expenses for the implementation, as described in this Attachment, exceed the $xx,xxx flat rate, an additional amount of up to $xx.xx per member per month, shall be reimbursed to HMO. This maximum funding amount has been calculated based on the average number of CCS Members assigned to HMO from July through September 2019.

B. Reimbursable Expenses. Reimbursement under the variable rate reimbursement category is limited to those expenses that were incurred prior to July 1, 2019. There are three broad categories of reimbursable expenses for the variable rate reimbursements, as follows:

1. Personnel Expenses—These expenses relate to the reassignment, recruitment and training of administrative personnel for implementation of the WCM, including both the cost of diverting existing staff (such as reassigning claims payment staff to prepare WCM-specific claims processing policies, procedures, and routines), the cost of recruiting new staff to carry out WCM-specific tasks (such as utilization management, case management, and claims processing for WCM services), and the cost of training (such as bringing in outside trainers, preparing training materials, and overseeing on-line training activities for staff on WCM-specific matters).

2. Systems and Infrastructure—These expenses include those expenses involved in establishing a DHCS-compliant WCM provider network, such as contracting and credentialing additional CCS-approved physicians and facilities; necessary modifications to electronic data systems; additional office equipment for new WCM-specific staff; acquisition of new software or new modules for existing software made necessary by operation of the WCM; and development of program reporting capabilities to meet the requirements of the CalOptima WCM program.

3. Other Expenses—This category includes other expenses incurred in preparation for the implementation of the WCM, such as member notifications, educational materials for members, providers, and/or HMO administrative staff, and other items that are dedicated to WCM implementation that are not covered by reimbursable expense categories 1. and 2.

C. Reimbursement

1. The flat fee reimbursement shall be paid by CalOptima on or before March 1, 2020.

2. The variable rate reimbursement shall be paid by CalOptima within thirty (30) days of confirmation that the following have been submitted, are consistent between the attestation and invoice (see below), are consistent with the costs that are reimbursable, and are accepted as complete:

2.1. An attestation, in the format designated by CalOptima, indicating the general nature and amount of expenditures incurred prior to July 1, 2019, for each of the three broad reimbursable expense categories, signed by an authorized signer for HMO.

2.2. A detailed invoice specifically describing the costs incurred, prior to July 1, 2019, in preparation for implementation of the WCM, as follows:

2.2.1 Personnel Costs—For HMO personnel costs in each category identify the job title, hours, and total compensation incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.2. Contractual Services—For services obtained from other than HMO personnel, indicate each contracted party, a general identification of the services provided, and the costs incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.3 Goods/Materials—For goods and materials, indicate the type of goods procured, from whom the goods were acquired, for what purpose the goods were used, and the cost of each type of goods obtained, and how the expenses relate to preparation for implementation of the WCM.

D. Audit.

1. CalOptima is not requiring that supporting documentation, such as contracts and invoices from providers of goods and services, or employment records for personnel undertaking preparations for implementation of the WCM, be provided with the attestation and invoices. However, HMO shall maintain such records in a reasonably accessible manner for inspection by CalOptima or its designated auditor.

2. CalOptima, or its designated auditor, shall audit HMO's records during the annual financial audit to verify that the expenses were incurred as reported in the invoicing

and attestation. Reimbursement of both flat and variable rate start-up expenses are subject to recoupment if substantiating documentation is not made available. Substantiating documentation may include, but not be limited to, salary and payroll information as described in Section 1.1.2; general ledger entries identifying the start-up expenses; contracts and invoices from third party providers of goods and services, and copies of cancelled checks to support payment of expenses.

3. Any variable rate reimbursement amounts that are found to not have been incurred, or not to be supported by sufficient documentation, shall be disallowed retroactively. Such disallowed amounts will constitute an overpayment and will be returned to CalOptima or recovered through offset, as provided elsewhere in this Contract.

E. Disputes. In the event that CalOptima disallows any expense incurred and properly attested and invoiced, HMO shall have the right to pursue those remedies identified in this Contract and CalOptima Provider Dispute and Appeals policies.

AMENDMENT IV TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IV TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____. ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the coronavirus known as COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-7, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E-7

MEDI-CAL RATE ENHANCEMENT

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). Pursuant to the action taken by CalOptima Board of Directors on April 2, 2020, in anticipation of a fluctuation in utilization by Medi-Cal members and the need for flexible services due to COVID-19, CalOptima amends the current Medi-Cal capitation base rate levels set forth in Attachment E to increase them by [redacted] for the period commencing April, 1 2020 and continuing through, and including, June 30, 2020.

MEDI-CAL

PHC – PHYSICIAN

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

_____

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES
PHYSICIAN

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered by and between Orange County Health Authority, a public agency, dba CalOptima ("CalOptima"), and _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Physician is a California professional medical corporation, which employs or otherwise contracts with physicians who are physicians licensed to practice medicine in the State of California.

D. Physician desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. Physician and the Hospitals set forth in Addendum I have affiliated to operate as a Physician-Hospital consortia ("PHC") for the purposes of providing or arranging for the provision of Covered Services to Members, as defined herein.

F. Physician recognizes that in order to comply with the requirements of this Contract, Physician and Hospital must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Physician and Hospital agree, both collectively and individually to coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Members.

G. CalOptima and Physician desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the Physician and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000."

1.8 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or Physician group.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the Physician by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or Physician group or from one Health Network or Physician group to another Health Network or Physician group; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in a Health Network or Physician group.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Physician. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on Physician, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as

Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network or Physician group regardless of Health Network or Physician group reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38"Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act").

1.45 "Health Network" means a physician hospital consortium (PHC), physician group, under a shared risk contract, or health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act). For the purposes of this Contract, Hospital is the hospital set forth in Addendum I.

1.49 “Incontinence Supplies” means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 “Joint Commission” means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 “Long Term Care Facility” means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 “Management Services Organization” or “MSO” means any organization, firm, company or entity providing Administrative Services on behalf of Physician which impact CalOptima Members.

1.53 “Medi-Cal” is the name for the Medicaid program in the State of California, and “Medicaid” is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 “Medi-Cal Fee Schedule” means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 “Medi-Cal Managed Care All Plan Letter (APL)” and “Policy Letter (PL)” are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 “Medically Necessary” or “Medical Necessity” means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).”

1.57 “Medical Record” means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 “Medical Screening Examination” or “MSE” means an examination within Physician’s capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and assigned to the PHC with which Physician participates.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks, Physician groups and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled with the PHC with which Physician participates.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Physician or Hospital to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Physician. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

1.77 "Physician Incentive Plan" means any compensation arrangement between Physician and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.80 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.81 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.82 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.83 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Physician, which limits the amount of risk or liability for the cost of providing Covered Services.

1.84 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

1.85 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing

1.86 Not Applicable to this Contract.

1.87 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.88 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.89 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.90 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.91 "Specialty Mental Health Services" means:

1.91.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.91.2 Psychiatric inpatient hospital services;

1.91.3 Targeted Care Management services;

1.91.4 Psychiatrist services;

1.91.5 Psychologist services; and

1.91.6 EPSDT supplemental specialty mental health services.

1.92 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.93 "State" means the State of California.

1.94 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.95 "Subcontract" means an agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.96 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.97 "Sub-delegation" means the process by which Physician expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Physician in order to meet its obligations under, and the intent of this Contract.

1.98 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.99 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.100 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of Physician – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Physician must establish and maintain, throughout the term of this Contract, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to [redacted] plus a minimum of [redacted] of one month's Capitation Payment.

Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION: Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS --

2.3.1 Professional/Medical Malpractice:

Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Physician and each Participating Provider shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Physician and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:

Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Insurer Ratings:
Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or
(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured:
Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change:
The PHC shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- PHC shall reimburse the Local Health Department (LHD) on a FFS basis according to the current Medi-Cal Fee Schedule for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract,

whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHC FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- PHC shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 As set forth in Attachment A, the Division of Financial Responsibilities, PHC shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 Not Applicable to this Contract.

2.7 PHYSICIAN PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - Physician and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

2.7.2 Claims Turnaround Time - Physician shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician, unless the claim or portion thereof is reasonably contested by Physician, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician in accordance with CalOptima Policy.

2.7.3 Claims Adjudication - Except as provided in this Section, Physician shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - Physician shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider

disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - Physician shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of Physician

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If Physician does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that Physician fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Physician for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that Physician fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from

Physician for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Physician Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Physician, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 Physician shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 Physician shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Physician, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 Physician's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 Physician shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. Physician will receive misdirected claims per CalOptima Policy.

2.7.9.2 Physician shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHC Payments – If FQHC, Physician shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - Physician shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Physician shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.7.13 Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information.

2.7.15 HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all

reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician.

2.7.16 Information Disclosures To Participating Providers. Physician shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments –

2.7.17.1 Physician shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than [redacted] of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by Physician and the physician and surgeon.

2.7.17.3 For CCS neonatal intensive care units, Physician shall pay the CCS Provider either the equivalent of Medi-Cal fee-for-service rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Physician's negotiated rates, whichever is higher, for up to 12 months after the transition.

2.7.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Physician shall make no claim for the recovery of the value of Covered Services rendered to a

Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Physician shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. Physician shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Physician shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Physician does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Physician shall follow the procedure above for cost avoidance. If Physician does not reimburse a Provider on a Fee-for-Service basis, then Physician shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Physician shall have written policies implementing these requirements.

2.9.4 Physician shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Physician shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Physician shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 Physician shall demonstrate to CalOptima that where Physician does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Physician projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- PHC shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%).

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- Physician shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. Physician shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.12 COOPERATION WITH DMHC --- Physician shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to Physician, in accordance with Section 1300.75.4.7 of Title 28 of the California Code of Regulations. Physician shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

2.13 RISK POOLS --- PHC in which Physician participates shall have risk pool arrangements/agreements between the Hospital and Physician parties of the PHC. Risk pool arrangements shall be pre-approved by CalOptima.

2.13.1 Hospital and Physician representatives shall annually negotiate and agree upon the terms and conditions of the risk sharing arrangement and shall submit the agreed upon terms and conditions to CalOptima by November 30, for each Contract year beginning January 1. Physician shall submit to CalOptima an attestation signed by an authorized signatory of both parties indicating that both the Hospital's and the Physician's Board of Directors

have approved the proposed terms and conditions. Terms and Conditions shall include the following:

2.13.1.1 Identification of services for which risk will be shared.

2.13.1.2 If risk sharing is based on utilization:

2.13.1.2.1 The expected utilization of services for which risk will be shared. Recommended measures are bed day/1000 Members for inpatient services and $ x.xx Per Member Per Month (PMPM) for other services.

2.13.1.2.2 The price or value for each of the services for which risk will be shared. These are the amounts each unit of service will be valued at and charged against the portion of the Hospital Capitation Payment that has been assigned to the risk sharing arrangement. Inpatient price is stated as per diem rates; other services are priced by fee schedules or as a percent of billed charges.

2.13.1.2.3 A proforma settlement calculation, which shall state the amount of surplus that is expected to result if utilization targets are achieved and agreed upon pricing is employed.

2.13.1.3 A description of audit or other procedures required to ensure the accuracy of the surplus or deficit calculation related to the cost and volume of services rendered under the arrangement and other revenues and expenses, including interest income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

2.13.1.4 Defined responsibilities for deficits should they occur.

2.13.1.5 Timing and documentation requirements for interim or final surplus distribution by Hospital.

2.13.2 Physician shall submit to CalOptima interim and final settlement calculations and an attestation from both Hospital and Physician stating that the above referenced terms and conditions have been properly applied, audit and reconciliation procedures have been performed, and that the amount of distribution to each party is consistent with the terms of the risk sharing agreement.

ARTICLE 3
Obligations of Physician - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY

3.2.1 Physician and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era Physician and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Physician and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 Physician and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Physician and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Physician and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Physician and its Subcontractors' commitments under the

provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Physician and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Physician and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Physician and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Physician and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive

Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Physician and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Physician and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Physician and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Physician shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Physician shall display the CalOptima logo on all Physicians' written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. Physician shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 MEMBER INQUIRIES AND CALLS --- Physician shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician's call center shall meet requirements established by CalOptima Policies. Physician shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Physician will be able to supply call center reports as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Physician shall ensure that all written Member information provided by Physician to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. Physician shall establish policies and procedures to enable

Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Physician. Physician shall implement and comply with CalOptima Policies relating to Member grievances. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Physician. Physician shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES --- Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Physician may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of Physician but shall not absolve Physician of oversight responsibilities. All sub-delegation must be approved by CalOptima. Physician shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Physician's sub-delegation to another entity does not alter Physician's ultimate obligation and responsibilities set forth in this Contract. Physician may give a sub-delegate the authority to act on behalf of Physician; but Physician retains oversight and accountability for the sub-delegated function. Accountability means that Physician cannot abdicate responsibility for the function being performed according to the requirements of this Contract, Physician's standards and those established by this Contract and CalOptima Policies. Physician is accountable for all functions performed in its purview whether by Physician, by any sub-delegate or by any sub-sub-delegate. If Physician chooses to sub-delegate a function, Physician must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, Physician shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Physician and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Physician evaluates the sub-delegate entity's performance; and

3.8.1.5 The Physician's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Physician's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Physician's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Physician's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Physician's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Physician shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Physician shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Physician's Members, including those receiving services from a sub-delegate of Physician.

3.8.6 Physician shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Physician shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Physician in this Contract and in

CalOptima Policies. Physician may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network or Physician group, or as a participant in a Health Network (i.e. Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Physician to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Physician shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, Physician shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination, or copying, in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.17 to 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10 and 7.11 of this Contract, and

to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Physician, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on Physician;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services, and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, as set forth in Attachment D of this Contract, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Physician cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Physician and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason, in accordance with Sections 8.2 and 8.2.1 of this Contract;

3.9.15 In the event that Physician implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Physician.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or Physician determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Physician to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- Physician shall comply with the following organization and operations structure requirements:

3.10.1 Single Board of Directors and management team.

3.10.2 Medical Director/CMO providing full time coverage. Duties shall include:

- Ensuring that medical decision are:
  - Rendered by qualified medical personnel
  - Are not unduly influenced by fiscal or administrative management considerations.
- Ensuring that the medical care provided meets the standards for acceptable medical care.
- Ensuring that medical protocols and Standards of Conduct for medical personnel are followed.
- Developing and implementing medical policy.
- Resolve grievances related to medical quality of care.
- Have a role in the implementation of Quality Improvement activities.
- Actively participate in the functioning of the grievance procedures.
- Actively participate in Quality activities including Credentialing and Peer Review.
- Acts as liaison and participates with CalOptima in any activities related to Medical Director/CMO duties.

PHYSICIAN shall report to CalOptima any changes in the status of the Medical Director within ten (10) calendar days.

3.10.3 No employee of Physician or Hospital in the PHC, including but not limited to Medical Director(s) and/or the Chief Medical Officer, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered

Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.10.4 Physician shall have a Single Credentialing Committee and credentialing policies, procedures and standards.

3.10.5 Physician shall have a Single and unified health care delivery system including but not limited to:

3.10.5.1 Participating Providers must be accessible to all members enrolled with Physician.

3.10.5.2 Members can select any contracted PCP with an open panel.

3.10.5.3 A PCP can refer members to any contracted specialist.

3.10.5.4 Physician must report to CalOptima all required data for the total enrollment of the Physician and the total provider network regardless of sub-delegation or other contractual relationships including but not limited to; complaints, encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

3.10.5.5 Centralized call center receiving all member and provider calls.

3.10.5.6 Single access number to call center.

3.10.5.7 Standard member communication for all members.

3.10.6 Other organization and operations structure requirements as may be established and modified from time to time by CalOptima.

3.11 ENROLLMENT --- PHC shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to PHC .

3.12 PCP ASSIGNMENT --- Physician shall assign Members who have been automatically assigned to Physician by CalOptima to a PCP within seven (7) days of the Member's assignment to Physician.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- Physician shall mail to a Member or Member's head of household a notice of enrollment and a Physician Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with Physician. All member handbooks and

supplements prepared by Physician shall be submitted to CalOptima for approval prior to printing. Physician shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should Physician choose to utilize the CalOptima Member handbook, Physician-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all Physicians' CalOptima Members. CalOptima shall provide Physician with a template for the supplement to the CalOptima member handbook.

3.13.2 If Physician chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, Physician's Member handbook shall contain all information included in the CalOptima Member handbook and Physician-specific information on each topic as defined by CalOptima Policies.

3.13.3 Physician shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. Physician shall also provide one (1) copy of its enrollment information including its Physician Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- Physician may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Physician shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with

CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Physician shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site,

3.17.1 Physician, PHC, and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Physician shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Physician, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Physician, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Physician, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Physician and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract, between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Physician or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving

matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Physician shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Physician or Subcontractor, Physician shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Physician shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts,

computers, or other electronic systems maintained by Physician and Subcontractors pertaining to these services at any time, pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Physician shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Physician's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Physician's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Physician's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Physician, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Physician. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Physician will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period specified in Section 3.18, Physician and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Physician's provision of and reimbursement for activities contemplated under the Contract, and to Physician's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law.

CalOptima employees shall sign Physician's statement of confidentiality prior to being admitted access to Physician's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Physician at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program; seek recovery of payments made to the Physician; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Physician shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time may be of the essence in responding to such request. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Physician or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Physician further agrees to timely gather, preserve, and provide to DHCS any records in the Physician's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Physician and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, Physician shall keep CalOptima informed as to the names of the officers and owners of Physician holding more than five percent (5%) of the stock issued by Physician, and major creditors holding more than five percent (5%) of the debt of Physician and shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician shall provide an accurate, current signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or Physician's employees, within two (2) working days of the date when Physician first becomes aware of or is on notice of such activity.

3.24.1 Physician shall notify CalOptima, and CalOptima shall notify DHCS prior to Physician conducting any investigations. Physician shall conduct an investigation after notification has been given.

3.24.2 Physician shall establish, for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Physician shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Physician shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Physician's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 PHYSICIAN COMPLIANCE PROGRAM --- Physician shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of the Inspector General's (OIG) 7 Elements of

an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Physician annually to ensure that it remains effective. Physician shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- Physician and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Physician's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician and Physician shall make them available to Physician's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Physician agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Physician acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Physician shall have policies and procedures to verify the Participation Status of Physician's Agents. Physician shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov) as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, Physician warrants and agrees as follows:

3.31.1 Physician and Physician's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Physician shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or

debarment by Physician or Physician's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Physician shall take immediate action to remove any Physician Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Physician shall include the obligations of this Section in its Subcontracts.

3.31.5 CalOptima and Physician, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Physician and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Physician and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and

activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Physician shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Physician shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Physician shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Physician shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Physician shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced_awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Physician shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Physician shall provide translation of written member informing materials in the Threshold and Concentration Languages. Physician shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Physician shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Physician shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Physician shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician or any Subcontractors, as well as member services, orientations,

appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Physician shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Physician shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Physician shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Physician shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Physician shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 Physician and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Physician shall comply with HIPAA requirements as currently established in CalOptima Policies. Physician shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Physician HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Physician and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Physician, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Physician's obligations under this Contract. Physician and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers,

device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Physician from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Physician is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Physician by DHCS for this purpose.

3.39 REINSURANCE --- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Physician may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E of this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Physician shall have a process for claims management and administration. Physician shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Physician shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Physician shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Physician shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Physician shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Physician shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Physician shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 PHYSICIAN SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Physician shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. Physician shall ensure that all Subcontracts are in writing and require that the Physician and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the final date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Physician understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Physician under this Contract. In instances where DHCS or CalOptima determines that the Physician or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations

to the Physician, (b) require the Physician to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Physician shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Physician or the oversight of those obligations.

ARTICLE 4
Obligations of Physician – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Physician shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Physician, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Physician shall provide Covered Services to Members and Physician agrees as follows:

4.1.1 Physician shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of Physician as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Physician's network is unable to provide necessary medical services covered under this Contract to a particular Member, Physician must adequately and timely cover these services out of network for the Member, for as long as Physician is unable to provide them. Physician shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Physician shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective PHC as to the Medical Necessity of the service, except that each PHC shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 Physician shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Physician denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Physician acknowledges that disputes between the respective Physician and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Physician may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Physician shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or Physician, CalOptima's or the Physician's insolvency, or breach of this Contract by the Physician or CalOptima, shall Physician or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit Physician or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. Physician or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and

a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Physician and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Physician's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Physician and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 ,That, in the event of a violation of this Section by Physician or Subcontractor, including, but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Physician or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Physician shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Physician reasonably determines that Emergency Services were never performed.

4.2.2 Not Applicable to this Contract.

4.2.3 Physician shall reimburse those physicians providing services in an Emergency Department with whom Physician has a contract according to

the terms of that contract. Physician shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. Physician shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 Not Applicable to this Contract.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Physician shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, Physician shall not deny payment for treatment obtained when PHC or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 Physician shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between Physician or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Physician may establish relationships with treating facility whereby the Physician may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency Physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on PHC and Physician.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Physician is financially responsible for post-stabilization services obtained within or outside Physician's network that are pre-approved by a plan provider or other entity representative. Physician is financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other Physician representative, but administered to maintain the Member's Stabilized condition within 1 hour

of a request to Physician for pre-approval of further post-stabilization care services.

4.2.8.1 Physician is also financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Physician does not respond to a request for pre-approval within 30 minutes; Physician cannot be contacted; or Physician's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Physician must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 Physician's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Not Applicable to this Contract.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, Physician is financially responsible for payment for post-stabilization services following an emergency admission. Physician shall reimburse those physicians providing post-stabilization services with whom Physician has a contract according to the terms of that contract. Physician shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- Physician shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Physician is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning

information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Physician shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Physician to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Physician from financial responsibility for such services.

4.4.2 Physician shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 Physician shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Physician shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Physician shall provide information to Members and Participating Providers about a Member’s right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician has restricted, prevented, impaired or denied the Member’s free choice of Family Planning Providers.

4.4.5 Physician shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Physician shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Physician shall arrange for the timely referral and coordination of Covered Services to which Physician or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES. Physician shall ensure the provision of SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician without first requesting a referral from a network Primary Care Physician. Physician shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM--- Physician acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and the PHC meeting DHCS access and other requirements as they apply to the PHC as a Health Network. Upon meeting those conditions, CalOptima shall notify Physician of the date upon which Physician will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time Physician shall commence all CalOptima WCM obligations."

ARTICLE 5
Obligations of Physician – Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Physician shall ensure that a physician Participating Provider or physician employed by Physician is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, Physician shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies.

5.2 URGENT CARE SERVICES --- Physician shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Physician shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with

CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Physician shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- Physician shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 HOSPITAL GEOGRAPHIC DISTRIBUTION --- Physician agrees that each hospital participating shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.6 DAYS TO APPOINTMENT --

5.6.1 Non-Emergency Covered Services – Physician shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. Physician shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – Physician shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. Physician shall arrange for the provision of specialty services from

specialists outside the network if unavailable within Physician's network, when determined medically necessary.

5.6.3 Preventive Covered Services – Physician shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services – Physician shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. Physician shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement – Physician shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization – within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services

provided to members who are receiving treatment for a chronic or ongoing medical condition or LTSS

5.7 OFFICE WAITING TIMES --- Physician shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject Physician to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- Physician shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Physician's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- Physician shall give Members thirty (30) calendar days' notice if their PCP withdraws from Physician. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- Physician shall offer each Member the opportunity to choose a PCP affiliated with the Physician. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in PHC. Physician shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Physician shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, Physician shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1	Primary Care Physicians	1:2,000 Members;
5.13.1.2	Total physicians and	1:1,200 Members;
5.13.1.3	If Non-Physician Medical Practitioners are included in Physician's Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.	

5.13.2 Supervising Physicians - Physician shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- Physician shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles from Member's place of residence.

5.16 PHYSICAL ACCESS --- Physician's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- Physician shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.
5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members

ARTICLE 6
Obligations of Physician – Clinical Quality

6.1 LICENSURE --- Physician shall ensure that every physician providing Covered Services and employed or engaged by Physician or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued

by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Physician shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Physician shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of the PHC or a multi-disciplinary QI Committee designated by the Board of Directors of PHC shall oversee the QI Program conducted by PHC. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from PHC. The QI Committee shall meet at least on a quarterly basis. PHC shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to PHC's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 PHC's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 PHC shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or PHC; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 PHC shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the PHC's QI Program shall be established by the PHC's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify PHC of any additional changes in QI standards and requirements that shall be incorporated in PHC's QI Program. PHC shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 PHC shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, PHC provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 PHC shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 Physician shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Physician shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Physician's Case Management Services program to determine compliance with Case Management Services standards. Physician shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Physician shall assure that Physician possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF PHYSICIAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Physician shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Physician shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Physician shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Physician shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to

form and content. When a Provider's contract is discontinued, and either the Provider or Physician decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician, but the rest of the group continues its contract with Physician, then Physician shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, Physician shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by Physician's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Physician shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- In its roles as a Health Network, PHC shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. Physician shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. Physician's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat CCS Eligible Conditions. However, Members cannot be limited to a single delegated entity's provider network. Physician must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, Physician may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated Physician shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated Physician shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Physician shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for

paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Physician shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 Physician shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, Physician shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 Physician shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by Physician, Physician remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Hospital must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, Physician may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Physician must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Physician's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Physician and the CCS Provider.

6.7.5.2.3 Physician confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to Physician, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, Physician and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, Physician shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Physician shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. Physician shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 Physician shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, Physician shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 Physician shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, Physician shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal

guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, PHC shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition PHC for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if Physician denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, PHC as applicable shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, PHC as applicable shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 PHC must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as PHC shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- Physician acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician. Physician shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima

Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 Physician shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 Physician shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. Physician shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 Physician shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 Not Applicable to this Contract.

6.9 BOARD CERTIFICATION --- Physician shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 Physician shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 Physician acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with Physician to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Physician shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Physician shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- PHC shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Physician shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Physician shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 PHC shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 Physician shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 Physician shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 Physician shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 Physician shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 Physician shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Physician shall develop referral and prior authorization policies and procedures to implement the above requirements. Physician shall submit these policies to CalOptima for review and approval;

6.11.8.9 Physician shall provide outpatient mental health services within the PCP's scope of practice. Physician shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. Physician shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. Physician shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU;

6.11.8.11 For Outpatient Mental Health Services, Physician shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, Physician shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use it as the Physician is able for the purpose of Member care coordination.

6.12 VACCINES --- Physicians shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with PHC's immunization policy. CalOptima shall not reimburse Physician for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 Physician may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- Physician agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF PHYSICIAN FOR SPD --- Physician shall provide the following for SPD Members:

6.15.1 Physician shall participate in the Community Liaison Program according to the guidelines and policies CalOptima promulgates to operate the program and as set forth in this Contract and CalOptima Policies;

6.15.2 Physician shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 Physician shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. Physician shall not restrict the Incontinence Supplies by brand name as

long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 Physician shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) Physician determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period.

6.15.5 Physician or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. Physician shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, Physician shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the Physician;

6.15.6 Physician shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. Physician shall provide to all SPD Members upon enrollment with PHC and at any time thereafter, upon the SPD Member's request, a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment with the PHC of an SPD Member, Physician shall complete a plan of care pursuant to CalOptima Policies. Physician shall update this plan as appropriate and/or annually. Physician shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies enrolled with PHC. PHC shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 Physician shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring

ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 Physician shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If Physician's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, Physician must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. Physician acknowledges that out-of-network providers must coordinate with Physician with respect to payment, and Physician shall ensure that such out-of-network providers understand this requirement. Physician must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. Physician shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, Physician shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept Physician or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, Physician shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions.

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members. The Profile shall include the compliance parameters required to receive PCC supplemental capitation.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.15 Physician shall be eligible to receive the supplemental PCC capitation as defined in Attachment E if Physician remains in good standing with CalOptima which shall include but not limited to the following:

6.15.15.1 No sanctions in place for the Medi-Cal program;
6.15.15.2 Resolution satisfactory to CalOptima of all identified Medi-Cal Program compliance deficiencies from the preceding calendar quarter;
6.15.15.3 Execution of all previous amendments; and
6.15.15.4 Other requirements contained in CalOptima Policy, as applicable

6.15.16 During any period in which CalOptima provides funding for the PCC program, and written notice that the program is active, Physician shall provide PCC services in accordance with the following:

6.15.16.1 Physician shall employ PCCs, and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. Physician shall staff one PCC per six hundred (600) CCS or SPD Members assigned to Physician. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP.

Physician shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.16.2 CalOptima shall provide Physician the Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to Physician thirty (30) days prior to the effective date of such change. If Physician is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30)-day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to Physician and termination of the Contract."

6.16 ADVANCE DIRECTIVES --- Physician shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Physician shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- Physician shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- Physician shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Physician shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. The Physician shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- Physician shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Physician shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, Physician and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of Physician – Reporting

7.1 DATA REPORTING REQUIREMENTS --- Physician shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Physician shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- Physician shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Physician shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Physician shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Physician shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Physician shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Physician should CalOptima determine that Physician is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Physician agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician as related to Members. Physician

shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If Physician is required to file monthly Financial Statements with the DMHC, Physician shall simultaneously file monthly Financial Statements with DHCS. Physician shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Physician shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Physician shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Physician's provider network.

7.6 PHYSICIAN ORGANIZATION PROFILE --- Physician shall report in compliance with CalOptima Policies, a profile of the Physician and PHC's organization, including, but not limited to, Physician and PHC's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Physician shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Physician, Physician shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Physician shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract.

7.8 DISCLOSURE --- PHC, Physician, and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician's or Subcontractor's financial records related to Physician's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Physician, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of

confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Physician shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – Physician shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies,

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Physician shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Physician to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Physician's letterhead signed by the Physician's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Physician – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Physician shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Physician at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Physician received Capitation Payment and termination occurred, Physician shall be paid according to

the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Physician shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Physician agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Physician.

8.3 TERMINATION PLANS --- Physician shall have a plan for the orderly termination of services under this Contract. Physician shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Physician acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Physician shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Physician acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Physician shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by

the number of Members enrolled with Physician, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Physician on or about the fifteenth (15^{th}) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Physician.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Physician an amount equal to twenty-five percent (25%) of the monthly Capitation Payment (Withhold). CalOptima may adjust Physician's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of Physician's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Physician. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Physician as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Physician shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- Physician has an obligation to report any overpayment identified by Physician, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Physician, or of receipt of notice of an overpayment identified by CalOptima. Physician acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician, CalOptima shall have the right to recover such amounts from Physician by recoupment or offset from current or future amounts due from CalOptima to Physician, after giving Physician notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Physician to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by Physician to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.
9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to Physician's capitation
9.4.6 Payments made by CalOptima that are the financial responsibility of Physician.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician paid by CalOptima against any funds owed to Physician by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Physician additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Physician any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Physician.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to PHC is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with PHC and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, PHC is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to PHC is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with PHC and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, PHC is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) -- In the event that an adult (age 21+ years) Member assigned to PHC is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with PHC and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, PHC is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY --- Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Physician shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician any material deficits.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician

acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Physician's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Physician accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Physician interpretation of MOUs entered into by CalOptima that are binding on Physician. Interpretation of MOUs will identify duties, obligation and responsibilities of Physician.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Physician acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Physician, information and data relating to the performance of Physician and PHC that CalOptima determines, among other things, would contribute to Providers', Members', and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Physician, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-

Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Physician the financial risk assumed under the Contract by providing to Physician the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Physician, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be

accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Physician the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Physician sufficient details to allow Physician to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Physician, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF PHC TERMINATION PLANS --- CalOptima shall review and approve Physician termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Physician's capitation withhold to Physician upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Physician of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply Physician's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Physician financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Physician insolvency. CalOptima shall release to Physician financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Physician may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the Physician

ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 MEMBER LIAISON PROGRAM (MLP) --- Physician shall establish and maintain support for the Member Liaison Program, including but not limited to:

12.2.1 Providing SPD Members and their caregivers with assistance to navigate the Medi-Cal managed care system;

12.2.2 Coordinating the range of Covered Services needed by SPD Members and assisting SPD Members in understanding and utilizing Physician's referral process;

12.2.3 Ensuring SPD Members receive appropriate and timely referrals;

12.2.4 Identifying barriers faced by SPD Members and integrating recommendations into the delivery system to improve access;

12.2.5 Keeping Physician and Participating Providers educated and sensitive to the needs of persons with disabilities;

12.2.6 Assisting PCPs to fully understand individual SPD Members' needs and provide physicians with access to the many community based resources available;

12.2.7 Providing feedback to CalOptima regarding necessary program modifications/enhancements;

12.2.8 Providing access to SPD Members information necessary for coordination of Covered Services across all Physician departments;

12.2.9 Assisting in the promotion, outreach and community awareness of the MLP.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's

Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards, are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Physician's Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements; (xvi) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvii) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xviii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Physician or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period

shall result in CalOptima deducting the penalty plus the administrative fee from the Physician's Capitation Payment.

13.1.2.2 Physician may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause – Notwithstanding, and in addition to, any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Physician may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Physician shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, Physician shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of Physician.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Physician in the event that membership in the PHC in which Physician participates falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of Physician's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Physician fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days

written notice should Physician fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Physician that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should Physician fail to comply with requirements for Physician's organization and operation structure established in this Contract and CalOptima Policies.

13.8 TERMINATION OR SANCTION FOR TERMINATION OR SANCTION OF THE PHC PARTNER --- This Contract shall terminate upon the termination of the Contract of the other party in the PHC. Notification of termination to any party in the PHC shall constitute notification of termination to all parties in the PHC. CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all parties in the PHC independent of the party in the PHC whose action(s) caused sanctions to be applied by CalOptima.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR PHYSICIAN INSOLVENCY --- If Physician becomes insolvent, Physician shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1.

In the event of the filing of a petition for bankruptcy by or against Physician or a principal Subcontractor, Physician shall assure that all Physician's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician until Physician fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician obligations have been met.

13.11 TERMINATION BY PHYSICIAN FOR CAUSE --- Provided that Physician is not in default hereunder, Physician may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to Physician under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to Physician any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW--- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Physician in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Physician shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- CalOptima may establish key performance measures of Physician to set minimum contract performance thresholds and/or pay financial incentives to Health Networks and Physician groups. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician, terminate this Contract, and establish Capitation Rates and other payments to Physician.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Physician agrees as follows:

13.14.1 CalOptima reserves the right to require Physician, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that Physician Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Physician terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such

Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks or Physician groups, Physician shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event Physician elects not to participate in any extension period or new contract term.

13.16 PHC PRIMARY HOSPITAL USAGE REQUIREMENT --- In order to qualify as a PHC, for any contract year period during the term of this Contract, at least seventy percent (70%) of the bed days for those Members assigned to the PHC who require inpatient hospitalization during the previous calendar year, or such other measurement period as may be adopted by the CalOptima Board of Directors, must have received their inpatient services from the PHC's Primary Hospital partner, or from a hospital within the same hospital system as the Primary Hospital, except as otherwise provided under CalOptima Policy. For purposes of calculation of the bed day percentage, only bed days in Orange County hospitals shall be considered. Failure to meet this requirement shall be cause for termination under Section 13.1.3 of this Contract. In the event of termination as a result of this Section, Physician shall be offered the opportunity to continue participation through a risk sharing arrangement, subject to meeting all applicable financial, operational, and other criteria for such an arrangement. Termination of a Primary Hospital under this Section shall have no effect on any fee-for-service contract between CalOptima and the Hospital.

13.17 EXTENSION, RENEWAL, OR MODIFICATION – Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF PHYSICIAN --- CalOptima and Physician agree that Physician and any agents or employees of Physician, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or

otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. Physician shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION --- Physician agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as

applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician or Subcontractor; (iii) the merger, reorganization, or consolidation of Physician or Subcontractor with another entity with respect to which Physician or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Physician or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Physician or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Physician agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the Physician certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement,

theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Physician is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Physician knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of

applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION---

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.2.2.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled “Standard Form-LLL ‘Disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed

by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid,

addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: Physician

_____

_____

_____

_____

14.18 GOVERNMENT CLAIMS ACT --- Physician shall ensure that Physician and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code sections 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE _____ THROUGH _____.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Contract:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM I

ENTITIES COMPRISING PHYSICIAN-HOSPITAL CONSORTIUM/CONSORTIA

By this Addendum, the undersigned attests that _____,
(Name of Physician)

a California professional medical corporation, which employs or otherwise contracts with physicians licensed to practice medicine in the State of California ("Physician"), and

_____, an acute care hospital ("Hospital"), have
(Name of Hospital)

affiliated to operate as a physician-hospital consortia (“PHC”) for the purposes of providing or arranging for the provision and payment of Covered Services to Members in compliance with the Contract for Health Care Services.

For Physician:

_____
Signature

_____
Print Name

_____
Title

_____
Date

Contract for Health Care Services

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	-See Transportation-		
Amniocentesis	X		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	X		
Facility component		X	
Birth Control	-See Family Planning-		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
CBAS			**CalOptima (Claims)**
CHDP	-See Pediatric Preventative Services-		
Chemotherapy			
Professional component	X		
Outpatient Facility component		X	
Medication	-See Medication-		

	Physician	Hospital Budget	Other
Chiropractic Services	X		
Cosmetic Surgery (Medically Necessary)			
Professional component	X		
Facility component (licensed surgical center or acute care facility only)		X	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	X		
Facility component		X	
Anesthesia Services			
Professional component (Other than provided by Dentist)			
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component			
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	X		
Facility component		X	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	X		
Facility component	X		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	X		
Facility component		X	
Dialysis			
Professional component	X		
Facility component		X	
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		X	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	X		
Custom Wheelchair Assessment	X		

	Physician	Hospital Budget	Other
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		X	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	X		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		X	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services			
Acupuncture	X		
Autism Screening	X		
Audiology	X		
Chiropractic	X		
Cochlear Implant	X		
Dental Services			**State**
EPSDT Case Management	X		
Hearing Aid Batteries	X		
In-Home Private Duty Nursing (PDN)	X		
Medical Nutrition Services	X		
Occupational Therapy	X		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	X		
Mental Health – Specialty Outpatient			**OC HCA/ State**
Family Planning (all provider types)			
Professional component	X		
Surgically implanted sterilization devices		X	
IUDs (with or without medication)	X		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	X		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		

	Physician	Hospital Budget	Other
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables	***- See Medications -***		
Immunizations	***- See Preventive Services -***		
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	

	Physician	Hospital Budget	Other
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including ~~c~~ chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission			
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Partial Hospitalization Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	

	Physician	Hospital Budget	Other
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Ttreatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient -DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	

Occupational Therapy	*- See Rehabilitation -*		
Orthotics	**X**		
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*		
	Physician	**Hospital Budget**	**Other**
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	*- See Medication -*		
Physical Therapy	*- See Rehabilitation -*		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	*- See Diagnostic Services -*		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	*- See Long Term Care Services -*		
Short stay	*- See Hospitalization -*		
Speech Therapy	*- See Rehabilitation -*		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			

Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated:_____ Signature:_____

Name:_____
(Please type or print)

Title:_____
(Please type or print)

ATTACHMENT C

Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective July 1, 2019

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Family/Poverty/Child	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Low Income Children Program (formerly Healthy Families)	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Adult	All Ages Both			
Aged	All Ages, Both			
Disabled	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
ESRD - Family	All ages, Both			
ESRD - Poverty	All ages, Both			
ESRD - Child	All ages, Both			
ESRD - Adult	All ages, Both			
ESRD - Aged	All ages, Both			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD - Disabled	All ages, Both			
ESRD - MCX	All ages, Both			
ESRD - MSI	All ages, Both			
AIDS - Family	All ages, Both			
AIDS - Poverty	All ages, Both			
AIDS - Child	All ages, Both			
AIDS - Adult	All ages, Both			
AIDS - Aged	All ages, Both			
AIDS - Disabled	All ages, Both			
AIDS - MCX	All ages, Both			
AIDS - MSI	All ages, Both			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Whole Child Model Base Capitation Rates

The following Whole Child Model payment provisions are effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program.

The following base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

	Hospital	Physician	Total Capitation
Whole Child Model			

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Funding for PCC

In addition to those amounts described above, HMO shall receive [redacted] per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all

age groups. CCS member is identified by their CCS Eligible condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Members with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-1
Capitation Rates for Adult Expansion Members

Effective July 1, 2019 through June 30, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code	Age & Gender	Base Cap Rate		
Category	Category	Hospital	Physician	Total
Expansion (MCX)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
Expansion (MSI)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least [redacted] of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment F-1 is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

- Payment rates shall be as follows:
  - Physician payment [redacted]
  - Hospital payment [redacted]

Funding for PCC – Effective October 1, 2018

In addition to those amounts described above, HMO shall receive [redacted] per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups and CCS member is identified by their CCS Eligible Condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-2
DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a [redacted] administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a [redacted] administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT F-1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C , Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g , Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

AMENDMENT I TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT I TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of October 1, 2019 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician wish to enter into this amendment to restate the Division of Financial Responsibilities and Formulary Medical Supplies as well as provide information and requirements related to supplemental payments for certain home health agency services.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility" shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I.

2. Attachment C, "Formulary Medical Supplies" shall be deleted in its entirety and replaced with the attached Attachment C – Amendment I.

3. Attachment E-3, "Supplemental Payment for Home Health Agency Services", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services
Amendment I

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party				
	Physician		**Hospital**		**Other**
Acupuncture	**X**				
Allergy Testing & Treatment					
Testing	**X**				
Serum	**X**				
Immunotherapy injections	**X**				
Ambulance	***- See Transportation -***				
Amniocentesis	**X**				
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)					
Professional component	**X**				
Facility component			**X**		
Birth Control	***- See Family Planning -***				
Blood and Blood Products					
From blood bank			**X**		
Transfusions, blood and blood components			**X**		
Autologous Transfusion (including collection of)			**X**		
Outpatient Transfusion, Blood and Blood Components			**X**		
Breast Implant (post-mastectomy) or Removal (medically necessary only)					
Professional component	**X**				
Facility component			**X**		
Breast Reconstructive Surgery (after cancer)					
Professional component	**X**				
Facility component			**X**		
CBAS					***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***				
Chemotherapy					
Professional Component	**X**				
Outpatient Facility Component			**X**		
Medication	***- See Medication -***				

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)	**X**				
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				

	Physician		Hospital		Other
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				

	Physician		Hospital		Other
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				

	Physician		Hospital		Other
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				

	Physician		Hospital		Other
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component	**X**				
Outpatient facility component	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***

	Physician		Hospital		Other
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***					
[2] ***Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.***					

ATTACHMENT C

Amendment I

Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

Respiratory Items

- Inhaler Assist Devices
- Nasal Aspirator
- Peak Flow Meters, Non-Electric

Contraceptive Items

- Condoms
- Diaphragms

Diabetic Supplies

- Blood Glucose Monitors (excludes Continuous Glucose Monitors which are covered as DME)
- Insulin Syringes
- Lancets
- Lancet Auto Injectors
- Blood Glucose Test Strips
- Urine Test Strips
- Alcohol Pads

ATTACHMENT E-3

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the [redacted] payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by [redacted] effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, Physician will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the Physician's reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

AMENDMENT II TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT II TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Health Homes Program.

NOW, THEREFORE, the parties agree as follows:

1. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

"1.102 Community-Based Care Management Entity (CB-CME) means Physician when providing Health Homes Program (HHP) services to HHP Members pursuant to this Contract.

1.103 Health Homes Program or "HHP" means all of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for provision of HHP services that provide supplemental services to HHP eligible and enrolled Members by coordinating and integrating the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed for chronic conditions.

1.104 HHP Member who is HHP enrolled, and continuously participating in the HHP and assigned to the Physician.

1.105 HHP Multi-Disciplinary Care Team means a team of staff employed or contracted by the Physician, as a CB-CME, that provides HHP services to HHP Members."

2. Section 6.22 shall be added as follows:

"6.22 HEALTH HOMES PROGRAM ---

6.22.1 Physician shall begin participating in CalOptima Health Homes Program, as follows: (i) Effective January 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible chronic physical conditions and substance use disorders; and (ii) Effective July 1, 2020, or such later date as determined by DHCS, for HHP Members with eligible serious mental illness.

6.22.2 Physician shall be responsible for providing and coordinating HHP services as one of the designated Community-Based Care Management Entities (CB-CMEs). Physician, as a CB-CME, shall ensure its systems and infrastructure are in place to provide HHP services to HHP Members.

Physician, as a CB-CME, shall satisfy the CB-CME qualification standards as defined by DHCS and CalOptima Policy, and CB-CME certification requirements as described in DHCS HHP Program Guide.

6.22.3 Physician shall comply with all State and federal requirements related to HHP and HHP requirements determined by DHCS, including the All Plan Letter related to Health Homes Program requirements and the HHP Program Guide. Physician, as a CB-CME, shall implement CalOptima Health Homes Program in accordance with this Contract and CalOptima Policies. Physician shall ensure that Physician staff who will be delivering HHP services complete training required by CalOptima and DHCS prior to participating in the administrative of the HHP.

6.22.4 Physician, as a CB-CME, shall be responsible for coordinating care with HHP Members, Providers, and other agencies as appropriate. Physician shall provide the following six (6) core HHP service categories for HHP Members: (i) Comprehensive care management; (ii) Care coordination; (iii) Health promotion; (iv) Comprehensive transitional care; (v) Individual and family support services; and (vi) Referral to community and social supports.

6.22.5 Physician shall maintain an aggregate minimum care coordinator ratio as defined by DHCS. Physician shall ensure the establishment of HHP Multi-Disciplinary Care Teams to provide HHP services, as set forth in CalOptima Policy GG.1331.

6.22.6 Physician shall ensure availability of Providers with experience working with people who are chronically homeless, pursuant to Welfare & Institutions Code section 14127.31(d)(1)(B).

6.22.7 Physician shall establish, as necessary, contractual relationships with organizations to provide HHP services (including but not limited to office visit accompaniment, housing navigator, individual housing transition services, and individual housing and tenancy sustaining services), and contractual or non-contractual relationships to provide linkages to community and social support services. Regardless of the subcontracting arrangement, Physician shall retain overall responsibility for all CB-CME duties and responsibilities set forth in this Contract and CalOptima Policies.

6.22.8 Physician shall conduct outreach and engagement activities for HHP-eligible Members who are not enrolled in HHP. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent to HHP participation may be oral or in writing and shall be documented by the Physician's Customer Service staff or HHP Multidisciplinary Care Team staff prior to the Member's participation in HHP. CalOptima and Physician will coordinate to ensure that Members who meet exclusionary criteria are excluded or disenrolled from the HHP pursuant to the HHP Program Guide and CalOptima Policy GG.1350.

6.22. 9 Physician, as a CB-CME, shall complete a health needs assessment (HNA) and develop a health action plan (HAP) for each HHP Member. Physician shall ensure case conferences are conducted by the HHP Multidisciplinary Care Team and the HHP Member's HNA and HAP are updated as necessary.

6.22.10 Physician may use HHP funding to make payments to HHP Members' network Providers who are not included formally on the Physician's HHP Multi-Disciplinary Care Team, but who are responsible for coordinating with the Physician's HHP care coordinator to conduct case conferences and to provide input to the health action plan (HAP).

6.22.11 In addition to other provisions of this Contract, Physician shall comply with CalOptima Policies GG.1331, GG.1350 and FF.4001 related to CB-CME duties and responsibilities, including engagement activities, the DHCS HHP Program Guide, and CB-CME requirements set forth in Welfare & Institutions Code, section 14127.3(d)(1).

6.22.12 Physician's Agent's Qualifications. Physician shall verify the qualifications of all agents (including Physician staff) providing services under this Contract consistent with the services to be provided under the Health Homes Program. In addition, for agents that enter into Members' homes or have face-to-face contact with Members, Physician shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Physician shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

6.22.13 HHP Data Sharing. CalOptima and Physician agree to exchange available information and data as required by DHCS for the HHP, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of HHP Members. CalOptima and Physician shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements, and other federal and California state laws and regulations, including applying the minimum necessary standard, when applicable. Further, Physician shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an HHP Member's valid authorization for release of health information and a legal exception does not apply, Physician may not release such information without the HHP Member's valid authorization.

6.22.14 HHP Data Reporting. Physician shall submit to CalOptima complete, accurate, reasonable and timely data reports in the manner and form acceptable to CalOptima in order for CalOptima to meet its data reporting requirements to DHCS for the HHP."

3. Attachment E-4, "Funding for Health Homes Program", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-4

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to Physician for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

   1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
   - Member is enrolled in the HHP;
   - Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the Physician, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the Physician;
   - The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
   - If applicable, the Physician paid the provider for the HHP core services; and
   - The Physician authorized such HHP core services.

   [redacted] PMPM (January – June 2020)
   PMPM (July – December 2020)

2. Engagement Activities Supplemental Capitation Payment

   2.1 Subject to Section 2.2 of this Attachment E-4, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

   - Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
   - The Physician conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
   - Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
   - If applicable, the Physician authorized and paid the provider for such engagement

   [redacted] PMPM (January – June 2020)
   PMPM (July – December 2020)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. Physician shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15^{th}) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT III TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT III TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract for the allocation and distribution of Intergovernmental Transfer (IGT) 6 and 7 Funds for Whole-Child Model (WCM) Startup Expenses incurred by Physician. IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 1–7 funds are designated for enhanced/additional benefits for Medi-Cal beneficiaries.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-5, "Whole-Child Model (WCM) Start-up Expenses Reimbursement", shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Attachment E-5

Whole-Child Model (WCM) Program Start-up Expense Reimbursement

This attachment sets forth the program of additional compensation for Whole Child Model (WCM) start-up expenses, as authorized by the CalOptima Board of Directors at its December 5, 2019, meeting.

A. Reimbursement Available. There are two parts of the expense related reimbursement payments available to Physician.

1. Flat Rate: Physician shall receive a one-time payment amount of [redacted] AND,

2. Variable Rate: If expenses for the implementation, as described in this Attachment, exceed the [redacted] flat rate, an additional amount of up to [redacted] per member per month, shall be reimbursed to Physician. This maximum funding amount has been calculated based on the average number of CCS Members assigned to Physician from July through September 2019.

B. Reimbursable Expenses. Reimbursement under the variable rate reimbursement category is limited to those expenses that were incurred prior to July 1, 2019. There are three broad categories of reimbursable expenses for the variable rate reimbursements, as follows:

1. Personnel Expenses—These expenses relate to the reassignment, recruitment and training of administrative personnel for implementation of the WCM, including both the cost of diverting existing staff (such as reassigning claims payment staff to prepare WCM-specific claims processing policies, procedures, and routines), the cost of recruiting new staff to carry out WCM-specific tasks (such as utilization management, case management, and claims processing for WCM services), and the cost of training (such as bringing in outside trainers, preparing training materials, and overseeing on-line training activities for staff on WCM-specific matters).

2. Systems and Infrastructure—These expenses include those expenses involved in establishing a DHCS-compliant WCM provider network, such as contracting and credentialing additional CCS-approved physicians and facilities; necessary modifications to electronic data systems; additional office equipment for new WCM-specific staff; acquisition of new software or new modules for existing software made necessary by operation of the WCM; and development of program reporting capabilities to meet the requirements of the CalOptima WCM program.

3. Other Expenses—This category includes other expenses incurred in preparation for the implementation of the WCM, such as member notifications, educational materials for members, providers, and/or Physician administrative staff, and other items that are dedicated to WCM implementation that are not covered by reimbursable expense categories 1. and 2.

C. Reimbursement

1. The flat fee reimbursement shall be paid by CalOptima on or before March 1, 2020.

2. The variable rate reimbursement shall be paid by CalOptima within thirty (30) days of confirmation that the following have been submitted, are consistent between the attestation and invoice (see below), are consistent with the costs that are reimbursable, and are accepted as complete:

2.1. An attestation, in the format designated by CalOptima, indicating the general nature and amount of expenditures incurred prior to July 1, 2019, for each of the three broad reimbursable expense categories, signed by an authorized signer for Physician.

2.2. A detailed invoice specifically describing the costs incurred, prior to July 1, 2019, in preparation for implementation of the WCM, as follows:

2.2.1 Personnel Costs—For Physician personnel costs in each category identify the job title, hours, and total compensation incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.2. Contractual Services—For services obtained from other than Physician personnel, indicate each contracted party, a general identification of the services provided, and the costs incurred, and how the expenses relate to preparation for implementation of the WCM.

2.2.3 Goods/Materials—For goods and materials, indicate the type of goods procured, from whom the goods were acquired, for what purpose the goods were used, and the cost of each type of goods obtained, and how the expenses relate to preparation for implementation of the WCM.

D. Audit.

1. CalOptima is not requiring that supporting documentation, such as contracts and invoices from providers of goods and services, or employment records for personnel undertaking preparations for implementation of the WCM, be provided with the attestation and invoices. However, Physician shall maintain such records in a reasonably accessible manner for inspection by CalOptima or its designated auditor.

2. CalOptima, or its designated auditor, shall audit Physician's records during the annual financial audit to verify that the expenses were incurred as reported in the invoicing and attestation. Reimbursement of both flat and variable rate start-up expenses are subject to recoupment if substantiating documentation is not made available. Substantiating documentation may include, but not be limited to, salary and payroll information as described in Section 1.1.2; general ledger entries identifying the start-up expenses; contracts and invoices from third party providers of goods and services, and copies of cancelled checks to support payment of expenses.

3. Any variable rate reimbursement amounts that are found to not have been incurred, or not to be supported by sufficient documentation, shall be disallowed retroactively. Such disallowed amounts will constitute an overpayment and will be returned to CalOptima or recovered through offset, as provided elsewhere in this Contract.

E. Disputes. In the event that CalOptima disallows any expense incurred and properly attested and invoiced, Physician shall have the right to pursue those remedies identified in this Contract and CalOptima Provider Dispute and Appeals policies.

AMENDMENT IV TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IV TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the coronavirus known as COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-6, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E-6

MEDI-CAL RATE ENHANCEMENT

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). Pursuant to the action taken by CalOptima Board of Directors on April 2, 2020, in anticipation of a fluctuation in utilization by Medi-Cal members and the need for flexible services due to COVID-19, CalOptima amends the current Medi-Cal capitation base rate levels set forth in Attachment E to increase them by [redacted] for the period commencing April, 1 2020 and continuing through, and including, June 30, 2020.

AMENDMENT V TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT V TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2020, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure and revise the capitation rates.

NOW, THEREFORE, the parties agree as follows:

1. Section 2.7.18. of the Contract, and any references thereto, shall be renumbered as Section 2.7.19, and new Section 2.7.18 shall be added to the Contract as follows:

   "2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and Physician shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-2, by Physician to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to Physician."

2. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

   "15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2021."

3. ATTACHMENT E shall be deleted and replaced with the attached ATTACHMENT E- AMENDMENT V "Capitation Rates".

4. ATTACHMENT E-1 shall be deleted and replaced with the attached ATTACHMENT E- 1 - AMENDMENT V "Capitation Rates for Adult Expansion Members".

5. ATTACHMENT E-2 "Distribution of Proposition 56 Funding" and Addendums to this Attachment shall be deleted and replaced with the attached ATTACHMENT E-2 – AMENDMENT V, "Distribution of Proposition 56 Funding".

5. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT V

Capitation Rates

Effective July 1, 2020

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment	[redacted]	[redacted]	[redacted]

Funding for PCC

In addition to those amounts described above, Physician shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset

Physician’s future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E-1 – AMENDMENT V

Capitation Rates for Adult Expansion Members

Effective July 1, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Expansion	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least [redacted] of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation

Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible Condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Member's with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

ATTACHMENT E-2 – AMENDMENT V

Distribution of Proposition 56 Funding

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    b. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    c. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent

payments, once Provider payment is confirmed, based on the monthly reports required by CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a [redacted] administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a [redacted] administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

15. Notwithstanding other provisions of this Attachment E-2, effective July 1, 2020, CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician wish to enter into this amendment to revise the Division of Financial Responsibilities, revise the Termination for Convenience provision as well as modify language as appropriate to align with all Health Care Services contracts.

NOW, THEREFORE, the parties agree as follows:

1. Section 1.16, "CalOptima Regulators", shall be deleted in its entirety and replaced with the following:

   "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforce applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Health Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

2. Section 1.22, "Community Liaison" or "CL", shall be deleted and intentionally left blank.

3. Section 1.23, "Community Liaison Program" or "CLP", shall be deleted and intentionally left blank.

4. Section 1.55, "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)", shall be deleted in its entirety and replaced with the following:

   "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

5. Section 1.64, "Memorandum/Memoranda of Understanding" or "MOU", shall be deleted in its entirety and replaced with the following:

   "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements,

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including but not limited to the Coordination and Provision of Public Health Care Services Contract.

6. Section 1.84, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)", shall be deleted in its entirety and replaced with the following:

"Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol."

7. Section 1.95, "Subcontract", shall be deleted in its entirety and replaced with the following:

"Subcontract" means a written agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

8. Section 1.96, "Subcontractor", shall be deleted in its entirety and replaced with the following:

"Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with Physician to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract."

9. Section 2.3.2 shall be deleted in its entirety and replaced with the following:

"Commercial General Liability/Commercial Automobile Liability:
Physician shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Physician's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract."

10. Section 2.3.8 shall be deleted in its entirety and replaced with the following:

"Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Physician shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Physician shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request."

11. Section 2.7.12, "Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments", shall be deleted in its entirety and replaced with the following:

"Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy."

12. Section 2.7.13, "Family Planning Provider Payments", shall be deleted in its entirety and replaced with the following:

"Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy."

13. Section 2.7.14, "Sexually Transmitted Disease Treatment Payments", shall be deleted in its entirety and replaced with the following:

"Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information."

14. Section 2.7.15, "HIV Testing and Counseling Payments", shall be deleted in its entirety and replaced with the following:

"HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician."

15. Section 3.4, "CALOPTIMA LOGO", shall be deleted in its entirety and replaced with the following:

"CALOPTIMA LOGO --- Physician shall not display the CalOptima logo on any of Physician's written communication to Members without prior written approval by CalOptima."

16. Section 3.9, "SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. Physician shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI

and CMS requirements for reporting information about Offshore Subcontracts. Physician shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, Physician shall require all Subcontracts contain the following:"

17. Section 3.9.2 shall be deleted in its entirety and replaced with the following:

"An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;"

18. Section 3.9.7 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;"

19. Section 3.9.8 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;"

20. Section 3.9.10 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;"

21. Section 3.9.12 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;"

22. Section 3.9.20 shall be deleted in its entirety and replaced with the following:

"An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement);"

23. Section 3.9.25 shall be deleted in its entirety and replaced with the following:

"An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and"

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24. Section 3.9.26 shall be added as follows:

"Subcontractor's agreement to provide Physician with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request."

25. Section 3.17, "MEDICAL AND ADMINISTRATIVE RECORDS", shall be deleted in its entirety and replaced with the following:

"MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). Physician shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site."

26. Section 3.19.1 shall be deleted in its entirety and replaced with the following:

"Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years."

27. Section 3.24, "FRAUD AND ABUSE REPORTING", shall be deleted in its entirety and replaced with the following:

"FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or Physician's employees, within five (5) working days of the date when Physician first becomes aware of or is on notice of such activity."

28. Section 3.24.2 shall be deleted in its entirety and replaced with the following:

"Physician shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program."

29. Section 3.28, "COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations."

30. Section 3.30, "COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s))", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. Physician agrees to require Subcontractors to comply with applicable requirements of such MOUs."

31. Section 3.42, "OBLIGATIONS UNDER PRIOR CONTRACT", shall be deleted in its entirety and replaced with the following:

"OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between Physician and CalOptima pursuant to which Physician agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members."

32. Section 4.2, "EMERGENCY CARE", shall be deleted in its entirety and replaced with the following:

"EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week."

33. Section 4.7, "ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES", shall be deleted in its entirety and replaced with the following:

"ALCOHOL MISUSE SCREENING AND COUNSELING --- Physician shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC."

34. Section 5.6.8 shall be deleted in its entirety and replaced with the following:

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"In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements."

35. Section 5.15, "SPECIALIST GEOGRAPHIC DISTRIBUTION", shall be deleted in its entirety and replaced with the following:

"SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence."

36. Section 6.4, "QUALITY IMPROVEMENT PROGRAM", shall be deleted in its entirety and replaced with the following:

"QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:"

37. Section 6.8.3.3 shall be deleted in its entirety and replaced with the following:

"An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS."

38. Section 6.15.1 shall be deleted and intentionally left blank.

39. Section 6.15.13 shall be deleted in its entirety and replaced with the following:

"Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by Physician pursuant to DHCS requirements and CalOptima Policies."

40. Section 10.2, "COMPREHENSIVE PHYSICIAN AUDIT", shall be deleted in its entirety and replaced with the following:

"COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut

and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician."

41. Section 10.7, "MOU AVAILABILITY", shall be deleted in its entirety and replaced with the following:

"MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website."

42. Section 10.10, "PROVIDER COMPLAINT SYSTEM", shall be deleted in its entirety and replaced with the following:

"PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and Physician shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system."

43. Section 12.2, "MEMBER LIAISON PROGRAM (MLP)", shall be deleted and intentionally left blank.

44. Section 13.1, "SANCTIONS AND TERMINATIONS FOR CAUSE," shall be deleted in its entirety and replaced with the following:

"SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing

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Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:"

45. Section 13.9, "TERMINATION FOR CONVENIENCE", shall be deleted in its entirety and replaced with the following:

"TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination."

46. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment VI.

47. Attachment E, "Capitation Rates", shall be deleted and replaced with the attached Attachment E – Amendment VI.

48. Attachment E-5, "Funding for Health Homes Program (HHP)" shall be deleted in its entirety and replaced with the attached Attachment E-5 – Amendment VI.

Commented [TC1]: PHC-P its under Attachment E-4 and needs to be updated on amendment

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT A – AMENDMENT VI

CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

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	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)			**X**		
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		

	Physician		Hospital		Other
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)'s***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				

	Physician		Hospital		Other
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				

	Physician		Hospital		Other
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***

	Physician		Hospital		Other
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation *					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
** CCS specific services are paid per Article 9.*					
[1] *Services are the responsibility of MTP if provided under the MTP program.*					
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*					

ATTACHMENT E – AMENDMENT VI

Capitation Rates

Effective January 1, 2021

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

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Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

Attachment E-5 – Amendment VI

Funding for Health Homes Program (HHP)

Effective January 1, 2020, CalOptima shall make a HHP Core Services Supplemental Capitation Payment to Physician for HHP services provided to an HHP-enrolled Member or a separate Engagement Activities Supplemental Capitation Payment for engagement activities for a Member eligible but not enrolled in HHP, in accordance with the terms and conditions of Policy FF.4001.

1. HHP Core Services Supplemental Capitation Payment

1.1 The HHP Core Services Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

- Member is identified as an HHP-eligible Member as determined by CalOptima based on HHP eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1350;
- Member is enrolled in the HHP;
- Member receives either one of the six (6) HHP core services (as set forth in Section 6.22.4 of the Contract) in a calendar month in which the supplemental payment is requested by the Physician, or the Member has received an HHP core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the Physician;
- The HHP core services are billed and reported to CalOptima consistent with the most recent HHP Program Guide or specific regulatory guidance as directed by DHCS;
- If applicable, the Physician paid the provider for the HHP core services; and
- The Physician authorized such HHP core services.

[redacted] PMPM (January – June 2020)
PMPM (July – December 2020)
PMPM (January – December 2021)

2. Engagement Activities Supplemental Capitation Payment

2.1 Subject to Section 2.2 of this Attachment E-5, the Engagement Activities Supplemental Capitation Payment below will be issued by CalOptima if all of the following conditions are met:

- Member is identified as an HHP-eligible Member as determined by CalOptima, based on HHP eligibility criteria as defined by DHCS but not enrolled in HHP
- The Physician conducted engagement activities to contact an HHP-eligible Member on CalOptima's Finalized Engagement List (FEL) for enrollment in HHP
- Engagement activities are billed and reported to CalOptima in the manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the HHP-eligible Member; and
- If applicable, the Physician authorized and paid the provider for such engagement

[redacted] PMPM (January – June 2020)
PMPM (July – December 2020)
PMPM (January – December 2021)

2.2 CalOptima shall limit the provision of Engagement Activities Supplemental Capitation Payment to a maximum of three (3) calendar months of billing per one (1) individual HHP-eligible Member who is not enrolled in HHP.

3. Physician shall submit HHP billing data for HHP Core Services Supplemental Capitation Payment and/or engagement activities billing data for Engagement Activities Supplemental Capitation Payment, as applicable, by the fifteenth (15th) calendar day after the month ends, in accordance with CalOptima Policy FF.4001.

4. Upon validation of the HHP billing data or engagement activities billing data, as applicable, CalOptima shall issue either the HHP Core Services Supplemental Capitation Payment or the Engagement Activities Supplemental Capitation Payment, as applicable, within thirty (30) business days from the date of the HHP billing data or engagement activities billing data submission, in accordance with CalOptima Policy FF.4001.

5. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of supplemental payment for HHP core services or engagement activities in accordance with CalOptima Policy FF.4001.

AMENDMENT VII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and Physician desire to amend the Contract to include the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. ATTACHMENT E-7 "MEDI-CAL RATE ENHANCMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Physician** have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT E-7

MEDI-CAL RATE ENHANCEMENT

For the period from January 1, 2021, through June 30, 2021, the base physician and base hospital capitation rates set forth in Attachment E – Amendment VI for the Child/Adult and SPD aid code categories shall be increased by [redacted]. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E – Amendment VI, Adult Expansion Member capitation rates in Attachment E-1 Amendment V, or the Health Homes Program supplemental capitation payments in Attachment E-5 – Amendment VI.

MEDI-CAL

PHC – HOSPITAL

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

HOSPITAL

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered into by and between Orange County Health Authority, a public agency, dba CalOptima ("CalOptima"), and _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Hospital is a general acute care hospital licensed under the laws of the State of California.

D. Hospital desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. Hospital and the Physicians set forth in Addendum I have affiliated to operate as a physician-hospital consortia ("PHC") for the purposes of providing or arranging for the provision of Covered Services to Members, as defined herein.

F. Hospital recognizes that in order to comply with the requirements of this Contract, Physician and Hospital must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Physician and Hospital agree, both collectively and individually to coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Members

G. CalOptima and Hospital desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of Hospital and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)."

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000."

1.8 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty one (2l) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.
B. A licensed acute care hospital approved by the CCS Program.
C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Hospital, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the Hospital by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Hospital's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or from one Health Network to another Health Network; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in the Health Networks.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Hospital. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on PHC in which Hospital participates, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network regardless of Health Network reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act").

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or a health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act). For the purposes of this Contract, Hospital is the hospital set forth in Addendum I.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of Hospital which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe

pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v)."

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within Hospital's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP) means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and the PHC with which Hospital participates.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program

(including Health Networks and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled in the PHC in which Hospital participates.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Hospital or Physician to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Hospital. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services, which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an

unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

1.77 Not Applicable to this Contract.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.80 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.81 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.82 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Hospital, which limits the amount of risk or liability for the cost of providing Covered Services.

1.83 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

1.84 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing.

1.85 Not Applicable to this Contract.

1.86 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.87 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.88 "Specialized Durable Medical Equipment means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.89 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.90 "Specialty Mental Health Services" means:

1.90.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.90.2 Psychiatric inpatient hospital services;

1.90.3 Targeted Care Management services;

1.90.4 Psychiatrist services;

1.90.5 Psychologist services; and

1.90.6 EPSDT supplemental specialty mental health services.

1.91 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.92 "State" means the State of California.

1.93 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.94 "Subcontract" means an agreement entered into by the Hospital with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Hospital specifically related to fulfilling Hospital's obligations to CalOptima under the terms of this Contract.

1.95 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Hospital. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.96 "Sub-delegation" means the process by which Hospital expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Hospital in order to meet its obligations under, and the intent of this Contract.

1.97 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.98 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.99 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.100 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of Hospital – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Hospital must establish and maintain throughout the term of this Contract financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one month's Capitation Payment. Hospital shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party

under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS ---

2.3.1 Professional/Medical Malpractice:
Each Hospital providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy with minimum limits as follows:

Hospital providing covered services:
$10,000,000 per incident/$10,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Each Hospital providing Covered Services to Members shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Each Hospital providing Covered Services to Members shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:
Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Not Applicable to this Contract.

2.3.5 Insurer Ratings:
Such insurance shall be provided by an insurer:
(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured:
Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change: The Hospital shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- PHC shall reimburse the Local Health Department (LHD) on a FFS basis according to the current Medi-Cal Fee Schedule for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHC FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- PHC shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 As set forth in Attachment A, the Division of Financial Responsibilities, PHC shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment, with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 HOSPITAL PAYMENTS TO PROVIDERS ---

2.6.1 Capitation Payments - Hospital and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Hospital receives payment from CalOptima.

2.6.2 Claims Turnaround Time - Hospital shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Hospital, unless the claim or portion thereof is reasonably contested by Hospital, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Hospital in accordance with CalOptima Policy.

2.6.3 Claims Adjudication - Except as provided in this Section, Hospital shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.6.4 Dispute Resolution - Hospital shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.6.5 Right Of Appeal - Hospital shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Hospital's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Hospital's Date of Determination.

2.6.6 CalOptima Payment On Behalf Of Hospital

2.6.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.6.6.2 If Hospital does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Hospital, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.6.7 Assumption of Delegated Functions.

2.6.7.1 Assumption Of Claims Processing. In the event that Hospital fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Hospital for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Hospital has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.6.7.2 Assumption Of Dispute Resolution. In the event that Hospital fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from Hospital for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.6.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Hospital Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Hospital, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.6.8 Quarterly Claims Payment Performance Report.

2.6.8.1 Hospital shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Hospital's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.6.8.2 Hospital shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Hospital, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.6.8.3 Hospital's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received,

categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.6.9 Forwarding of Misdirected Claims

2.6.9.1 PHC shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. PHC will receive misdirected claims per CalOptima Policy.

2.6.9.2 PHC shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.6.10 FQHC Payments - If FQHC, PHC shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.6.11 American Indian Health Service Payments - PHC shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Hospital shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.6.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in PHC's provider network, PHC shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.6.13 Family Planning Provider Payments - PHC shall reimburse non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy. PHC shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.6.14 Sexually Transmitted Disease Treatment Payments - PHC shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. PHC may elect to

provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to PHC along with billing information.

2.6.15 HIV Testing and Counseling Payments - PHC shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as identified in CalOptima Policy. PHC shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to PHC.

2.6.16 Information Disclosures To Participating Providers. Hospital shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.6.16.1 A complete fee schedule.

2.6.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.6.17 Not Applicable to this Contract.

2.6.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.7 SKILLED NURSING FACILITY FINANCIAL RESPONSIBILITY --- Hospital shall be financially responsible for Skilled Nursing Facility services daily rate when such services are determined by CalOptima to be in-lieu of acute hospitalization

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Hospital shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Hospital shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Hospital and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Hospital cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. Hospital shall coordinate benefits with other programs or entitlements recognizing

OHC as primary coverage and Medi-Cal as the payor of last resort. Hospital shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Hospital reimburses a Provider on a Fee-for-Service basis, Hospital shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Hospital reimburses a Provider on a Fee-for-Service basis, Hospital shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS, or in child support enforcement cases. If Hospital does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Hospital shall follow the procedure above for cost avoidance. If Hospital does not reimburse a Provider on a Fee-for-Service basis, then Hospital shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Hospital shall have written policies implementing these requirements.

2.9.4 Hospital shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Hospital shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Hospital shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 Hospital shall demonstrate to CalOptima that where Hospital does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Hospital projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- PHC shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%).

2.11 Not Applicable to this Contract.

2.12 Not Applicable to this Contract.

2.13 RISK POOLS --- PHC in which Hospital participates shall have risk pool arrangements/agreements between the Hospital and Physician parties of the PHC. Risk pool arrangements shall be pre-approved by CalOptima.

2.13.1 Hospital and Physician representatives shall annually negotiate and agree upon the terms and conditions of the risk sharing arrangement and shall submit the agreed upon terms and conditions to CalOptima by November 30, for each Contract year beginning January 1. Hospital shall submit to CalOptima an attestation signed by an authorized signatory of both parties indicating that both the Hospital's and the Physician's Board of Directors have approved the proposed terms and conditions. Terms and Conditions shall include the following:

2.13.1.1 Identification of services for which risk will be shared.

2.13.1.2 If risk sharing is based on utilization:

2.13.1.2.1 The expected utilization of services for which risk will be shared. Recommended measures are bed day/1000 Members for inpatient services and $ x.xx Per Member Per Month (PMPM) for other services.

2.13.1.2.2 The price or value for each of the services for which risk will be shared. These are the amounts each unit of service will be valued at and charged against the portion of the Hospital Capitation Payment that has been assigned to the risk sharing arrangement. Inpatient price is stated as per diem rates; other services are priced by fee schedules or as a percent of billed charges.

2.13.1.2.3 A proforma settlement calculation, which shall state the amount of surplus that is expected to result if utilization targets are achieved and agreed upon pricing is employed.

2.13.1.3 A description of audit or other procedures required to ensure the accuracy of the surplus or deficit calculation related to the cost and volume of services rendered under the arrangement and other revenues and expenses, including interest income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

2.13.1.4 Defined responsibilities for deficits should they occur.

2.13.1.5 Timing and documentation requirements for interim or final surplus distribution by Hospital.

2.13.2 Hospital shall submit to CalOptima interim and final settlement calculations and an attestation from both Hospital and Physician stating that the above referenced terms and conditions have been properly applied, audit and reconciliation procedures have been performed, and that the amount of distribution to each party is consistent with the terms of the risk sharing agreement.

2.14 CONTRACTS FOR HOSPITAL SERVICES --- At the request of a general acute care hospital that holds a contract with CalOptima for fee-for-service hospital services, PHC shall enter into a contract with said requesting hospital on the same terms and conditions, and for the same rates, contained in the CalOptima fee-for-service hospital contract.

ARTICLE 3
Obligations of Hospital - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY –

3.2.1 Hospital and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Hospital and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Hospital and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Hospital and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability,

age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 Hospital and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Hospital and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Hospital and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Hospital and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Hospital and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Hospital and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Hospital and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Hospital and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and

remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Hospital and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Hospital and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Hospital and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Hospital and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Hospital shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Hospital shall display the CalOptima logo on all Hospital's written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. Hospital shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 Not Applicable to this Contract.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Hospital shall ensure that all written Member information provided by Hospital to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written

Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. Hospital shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by Hospital. Hospital shall implement and comply with CalOptima Policies relating to Member grievances. Hospital shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Hospital. Hospital shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES --- Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Hospital may sub-delegate to a hospital, MSO, medical group and/or IPA administrative functions required of Hospital, but shall not absolve Hospital of oversight responsibilities. All sub-delegation must be approved by CalOptima. Hospital shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Hospital's Sub-delegation to another entity does not alter Hospital's ultimate obligation and responsibilities set forth in this Contract. Hospital may give a sub-delegate the authority to act on behalf of Hospital; but Hospital retains oversight and accountability for the sub-delegated function. Accountability means that Hospital cannot abdicate responsibility for the function being performed according to the requirements of this Contract, Hospital's standards and those established by this Contract and CalOptima Policies. Hospital is accountable for all functions performed in its purview whether by Hospital, by any sub-delegate or by any sub-sub-delegate. If Hospital chooses to sub-delegate a function, Hospital must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its membership and provider network. At a minimum, Hospital shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Hospital and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Hospital evaluates the sub-delegate entity's performance; and

3.8.1.5 The Hospital's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Hospital's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Hospital's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Hospital's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Hospital's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Hospital shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Hospital shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Hospital's Members, including those receiving services from a sub-delegate of Hospital.

3.8.6 Hospital shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Hospital shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Hospital in this Contract and in CalOptima Policies. Hospital may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network, or a participant in a Health Network (i.e. Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Hospital to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Hospital shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Hospital shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Hospital may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Hospital is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Hospital is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, Hospital shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment, and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 to 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.7, and 7.8 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Hospital, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on the Hospital and its affiliated PHC(s);

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Hospital of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed by and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Hospital cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Hospital and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract.

3.9.15 Not Applicable to this Contract.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Hospital delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or Hospital determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Hospital to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.11 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 Not Applicable to this Contract.

3.11 Not Applicable to this Contact.

3.12 SPECIAL DISENROLLMENT --- Hospital may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.13 ENROLLMENT --- PHC and Hospital shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to PHC.

3.14 Not Applicable to this Contract.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Hospital shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Hospital shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Hospital shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site,

3.17.1 Hospital, PHC and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Hospital shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Hospital, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Hospital, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Hospital, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Hospital and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Hospital or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Hospital shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including

subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Hospital or Subcontractor, Hospital shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Hospital shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Hospital's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Hospital shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by Hospital and Subcontractors pertaining to these services at any time, pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Hospital shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Hospital's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Hospital's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Hospital's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Hospital, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time, ''pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives

and designees will have the right to premises access, with or without notice to Hospital. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Hospital will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Hospital and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period specified in Section 3.18, Hospital and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Hospital's provision of and reimbursement for activities contemplated under the Contract, and to Hospital's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign Hospital's statement of confidentiality prior to being admitted access to Hospital's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Hospital at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Hospital from participation in the Medi-Cal program; seek recovery of payments made to the Hospital; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Hospital shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Hospital or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Hospital further agrees to timely gather, preserve, and provide to DHCS and records in the Hospital's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Hospital and its Subcontractors shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, Hospital shall keep CalOptima informed as to the names of the officers and owners of PHC and/or Hospital holding more than five percent (5%) of the stock issued by PHC and/or Hospital, and major creditors holding more than five percent (5%) of the debt of the PHC and/or Hospital and shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Hospital shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- Hospital shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of Network Providers, Members, or Hospital's employees, within two (2) working days of the date when Hospital first becomes aware of or is on notice of such activity.

3.24.1 Hospital shall notify CalOptima, and CalOptima shall notify DHCS prior to Hospital conducting any investigations. Hospital shall conduct an investigation after notification has been given.

3.24.2 Hospital shall establish for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Hospital shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Hospital shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Hospital's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 HOSPITAL COMPLIANCE PROGRAM --- Hospital shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of the Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Hospital annually to ensure that it remains effective. Hospital shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- Hospital and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Hospital's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Hospital and Hospital shall make them available to Hospital's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Hospital shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Hospital's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Hospital agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Hospital acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Hospital agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Hospital shall have policies and procedures to verify the Participation Status of Hospital's Agents. Hospital shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, Hospital warrants and agrees as follows:

3.31.1 Hospital and Hospital's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Hospital shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Hospital or Hospital's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Hospital shall take immediate action to remove any Hospital Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Hospital shall include the obligations of this Section in its Subcontracts.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Hospital nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Hospital and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Hospital and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Hospital shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Hospital and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on

the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Hospital, nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Hospital shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Hospital shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Hospital shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Hospital shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Hospital shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Hospital shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Hospital shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced_awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Hospital shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Hospital shall provide translation of written member informing materials in the Threshold and Concentration Languages. Hospital shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Hospital shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Hospital shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Hospital shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Hospital shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Hospital or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Hospital shall have in place telephonic and face-to-

face interpreter services and American Sign Language interpreter services contracts. Hospital shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Hospital shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Hospital must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Hospital shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Hospital shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Hospital shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Hospital shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Hospital shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Hospital shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 Hospital and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Hospital shall comply with HIPAA requirements as currently established in CalOptima Policies. Hospital shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Hospital and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Hospital, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Hospital and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Hospital's obligations under this Contract. Hospital and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Hospital shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information,

records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Hospital from unauthorized disclosure. Hospital may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Hospital is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Hospital or its Subcontractors, Hospital:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Hospital by DHCS for this purpose.

3.39 REINSURANCE --- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Hospital may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Hospital shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Hospital shall have a process for claims management and administration. Hospital shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Hospital shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 Not Applicable to this Contract.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Hospital acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Hospital shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Hospital shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Hospital shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Hospital's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Hospital shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 HOSPITAL SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Hospital shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copes of all Subcontracts. Hospital shall ensure that all Subcontracts are in writing and require that the Hospital and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Hospital understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Hospital under this Contract. In instances where DHCS or CalOptima determines that the Hospital or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the Hospital, (b) require the Hospital to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Hospital shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable

laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Hospital or the oversight of those obligations.

ARTICLE 4
Obligations of Hospital – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Hospital shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Hospital, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician in the PHC in which Hospital participates is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Hospital and Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Hospital shall provide Covered Services to Members and Hospital agrees as follows:

4.1.1 Hospital shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of Hospital as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Hospital's network is unable to provide necessary medical services covered under this Contract to a particular Member, Hospital must adequately and timely cover these services out of network for the Member, for as long as Hospital is unable to provide them. Hospital shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Hospital shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Hospital thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective PHC as to the Medical Necessity of the service, except that each PHC shall

provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 The Hospital shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Hospital denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Hospital acknowledges that disputes between the respective Hospital and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Hospital may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Hospital may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Hospital shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or Hospital, CalOptima's or the Hospital's insolvency, or breach of this Contract by the Hospital or CalOptima, shall the PHC, Hospital or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit the PHC, Hospital or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.9 of this Contract. Hospital or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Hospital further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Hospital and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Hospital's Subcontracts with Subcontractors, including Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Hospital and Subcontractors Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 That, in the event of a violation of this Section by Hospital or Subcontractor, including but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Hospital or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- Hospital shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). Hospital is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Hospital shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Hospital reasonably determines that Emergency Services were never performed.

4.2.2 Hospital shall reimburse or authorize reimbursement for facility changes for Emergency Services. Hospital is required to reimburse hospital when necessary for all MSE. If the MSE indicates that the Member has an Emergency Medical Condition as defined in Section 1.34, Hospital must reimburse or authorize reimbursement, as appropriate for all Covered Services Medically Necessary to diagnose and Stabilize the Member.

4.2.3 If the MSE indicates that the Member has an Emergency Medical Condition as defined in Section 1.34, Hospital must reimburse or authorize reimbursement, as appropriate, for all Covered Services Medically Necessary to diagnose and Stabilize the Member, provided without prior authorization. The emergency department of a treating facility shall notify Member's Health Network within twenty-four (24) hours of a CalOptima Member's Initial Emergency Encounter. For the purposes of this Section, Initial Emergency Encounter means the Member's presentation to the emergency department of the treating facility for outpatient Emergency Services or the Member's inpatient emergency admission to the treating facility, whichever occurs first. If the Initial Emergency Encounter occurs

on a holiday or weekend, notification to the Member's Health Network shall be made the following business day. Failure to notify the Member's Health Network as required in this Contract may subject Hospital to sanctions and other penalties as provided for in this Contract and CalOptima Policies. A treating facility's failure to notify Member's Health Network may be excused if the treating facility can document extenuating circumstances resulting in an inability of the treating facility to identify the Member, and/or the Member's Health Network.

4.2.4 If Hospital is treating a CalOptima beneficiary ("Other Member") enrolled in a Health Network with which Hospital does not participate or have a Subcontract, Hospital must contact the Other Member's Health Network as soon as the Emergency Medical Condition has been treated or Stabilized. The Other Member's Health Network shall not be held liable for continuing non-emergency care, which has not been authorized by Other Member's Health Network. Failure to notify the Other Member's Health Network as required in this Contract may subject Hospital to sanctions and other penalties as provided for in this Contract and CalOptima Policies. Treating facility's failure to notify the Other Member's Health Network may be excused if treating facility can document extenuating circumstances resulting in an inability of treating facility to identify the Other Member, the Other Member's Health Network or otherwise contact the Other Member's Health Network.

4.2.5 The components of the Emergency Services may vary according to the condition and medical history of the Member. Accordingly, all Clean Claims for Emergency Services shall be paid at the procedure code level supported by, and based on, the documentation submitted with the claims. For facilities with which Hospital has a contract, Hospital shall reimburse for those Emergency Services in accordance with that contract. For all other facilities, Hospital shall reimburse for those Emergency Services in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), CalOptima Policy, and State Contract, Exhibit A, Attachment 8, Provision 5, Claims Processing.

4.2.6 Hospital shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.7 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Hospital shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would have not resulted in an outcome specified in Section 1.34. Further, Hospital shall not deny payment for treatment obtained when PHC or a Participating Provider instructs the Member to seek Emergency Services.

4.2.8 Hospital shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.9 If there is a disagreement between Hospital or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Hospital may establish relationships with treating facility whereby the Hospital may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a hospital under contract with Hospital agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency Physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on PHC and Hospital.

4.2.10 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Hospital is financially responsible for post-stabilization services obtained within or outside Hospital's network that are pre-approved by a plan provider or other entity representative. Hospital is financially responsible for post-stabilization care services obtained within or outside Hospital's network that are not pre-approved by a plan provider or other Hospital representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to Hospital for pre-approval of further post-stabilization care services.

4.2.10.1 Hospital is also financially responsible for post-stabilization care services obtained within or outside Hospital's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Hospital does not respond to a request for pre-approval within 30 minutes; Hospital cannot be contacted; or Hospital's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Hospital must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.10.2 Hospital's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the

treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.10.3 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214 Hospital is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Section, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Section, shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by Hospital to a hospital that accurately reflects the payment amounts required by this Section shall constitute payment in full under this Section, and shall not be subject to subsequent adjustments or reconciliations by Hospital, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by Hospital pursuant to this Section.

4.2.10.4 Not Applicable to this Contact.

4.3 NEWBORN SERVICES --- Hospital shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 Not Applicable to this Contract.

4.5 Not Applicable to this Contract.

4.6 ACCESS TO SERVICES TO WHICH HOSPITAL OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Hospital shall arrange for the timely referral and coordination of Covered Services to which Hospital or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 Not Applicable to this Contract.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician

without first requesting a referral from a network Primary Care Physician. Hospital shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Program within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM--- Hospital acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and the PHC meeting DHCS access and other requirements as they apply to the PHC as a Health Network. Upon meeting those conditions, CalOptima shall notify Hospital of the date upon which Hospital will be considered to be "Participating in the CalOptima Whole Child Model Program" as that phrase is used in this Contract, and at which time Hospital shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of Hospital – Access

5.1 HOSPITAL GEOGRAPHIC DISTRIBUTION --- Hospital agrees that each hospital participating in the PHC in which Hospital is participating, shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.2 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Hospital shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.3 PHYSICAL ACCESS --- Hospital's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.4 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Hospital's or a Subcontractor's proposal to reduce or change the hours, days, or location at which

the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Hospital's proposal shall allow for timely notice to Members to allow them to change PCPs if desired.

ARTICLE 6
Obligations of Hospital – Clinical Quality

6.1 Not Applicable to this Contract.

6.2 HEALTH EDUCATION AND PREVENTION --- Hospital shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Hospital shall assist and support Physician to assure that, Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;

6.2.2 Refer Members to appropriate HEP, based on the Member's needs;

6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,

6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- PHC shall participate and cooperate in CalOptima's Quality Improvement Program. PHC shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. PHC shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and

Information Set (HEDIS)). PHC shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program."

6.4.4 The Board of Directors of the PHC or a multi-disciplinary QI Committee designated by the Board of Directors of the PHC shall oversee the QI Program conducted by PHC. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from PHC. The QI Committee shall meet at least on a quarterly basis. PHC shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to PHC's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 PHC's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 PHC shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or PHC; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 PHC shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the PHC's QI Program shall be established by the PHC's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify PHC of any additional changes in QI standards and requirements that shall be incorporated in PHC's QI Program. PHC shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 PHC shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, PHC shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 PHC shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 PHC shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- Hospital in conjunction with and in support of Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Hospital in conjunction with and in support of Physician shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Hospital and Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and

Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Hospital's and Physician's Case Management Services program to determine compliance with Case Management Services standards. Hospital shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 Hospital and Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Hospital shall assure that Hospital possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 Not Applicable to this Contract.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, PHC shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees

to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, Hospital shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, PHC shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by PHC's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, PHC shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, Hospital shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- In its role as a Health Network, PHC shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. PHC shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. PHC's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat CCS Eligible Conditions. However, Members cannot be limited to a single delegated entity's provider network. PHC must ensure Members have access to all Medically Necessary CCS-Paneled Providers

within CalOptima's provider network. In addition, PHC may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated PHC shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled providers who possess the appropriate knowledge and clinical experience. CCS delegated PHC shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Hospital shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, Hospital shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Hospital shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 PHC shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, PHC shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County

CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 PHC shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by PHC, PHC remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, Hospital shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Hospital must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, PHC may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, PHC must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Hospital's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Hospital and the CCS Provider.

6.7.5.2.3 Hospital confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to Hospital, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model. Before the previously prescribed drug is discontinued, PHC and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as PHC shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, PHC shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, PHC shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as PHC shall begin Participating in the CalOptima Whole Child Model Program, PHC shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. PHC shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or

Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 PHC shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, PHC shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 PHC shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, PHC shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, PHC shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, PHC shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition PHC for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if PHC denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, PHC shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Hospital shall begin Participating in the CalOptima Whole Child Model Program, PHC shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 PHC must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima policies. CalOptima shall ensure that CCS-Eligible Members enrolled in the CalOptima Whole Child Model Program are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 Not Applicable to this Contract.

6.9 Not Applicable to this Contract.

6.10 Not Applicable to this Contract.

6.11 COORDINATION AND CONTINUATION OF CARE --- Hospital in conjunction with and support of Physician shall have systems in place to ensure managed patient care for those services commonly available at Hospital, or that are delegated to Hospital by CalOptima and/or Physician, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Hospital shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Hospital shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 PHC shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 PHC shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 PHC shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 PHC shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 PHC shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 Not Applicable to this Contract.

6.11.8.8 PHC shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Hospital shall develop referral and prior authorization policies and procedures to implement the above requirements. Hospital shall submit these policies to CalOptima for review and approval;

6.11.8.9 Not Applicable to the Contract

6.11.8.10 Mental Health Services. PHC shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. PHC shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. PHC shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU;

6.11.8.11 For Outpatient Mental Health Services, PHC shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP’s scope of practice, Hospital in conjunction with and support of

Physician shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Hospital in conjunction with and support of Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 Hospital in conjunction with and support of Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Hospital and Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Hospital in conjunction with and support of Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Hospital is responsible for, or in conjunction with and support of Physician is responsible for the coordination of care for Members, CalOptima shall share with Hospital, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Hospital shall receive the utilization data provided by CalOptima and use it as the Hospital is able for the purpose of Member care coordination.

6.12 RESEARCH --- Hospital agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.13 ADVANCE DIRECTIVES --- Hospital shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Hospital shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.14 MEMBER VISITS --- Hospital shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Hospital shall include the requirement of this Section in its Subcontracts with such health facilities.

6.15 DHCS DIRECTIONS --- If required by DHCS, Hospital and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of Hospital – Reporting

7.1. DATA REPORTING REQUIREMENTS --- Hospital shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Hospital shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2. ENCOUNTER REPORTING --- Hospital shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Hospital shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Hospital shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Hospital shall be subject to financial penalties and/or sanctions if CalOptima determines that Hospital is reporting to CalOptima less than all facility encounters in the CalOptima required format and timelines. Hospital shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Hospital should CalOptima determine that Hospital is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Hospital agrees to provide the results of Hospital's and its Parent corporation's (where applicable) annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred-twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Hospital as related to Members. Hospital shall allow representatives of CalOptima, upon written request, to verify the financial report. Whenever audited Statements are required, Hospital may submit its parent company's Financial Statement, if audited Financial Statements are not prepared at Hospital level.

7.4 PARTICIPATING PROVIDER CONTRACTS --- Hospital shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Hospital, Hospital shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Hospital shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Hospital's obligations under this Contract.

7.5 DISCLOSURE --- PHC, Hospital and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of its Hospital's or Subcontractor's financial records related to Hospital's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.6 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Hospital, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Hospital shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Hospital had reasonable control to avoid the disclosure.

7.7 PROVIDER DATA – Hospital shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meets its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.8 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Hospital shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.9 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Hospital to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Hospital's letterhead signed by the Hospital's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Hospital – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Hospital shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Hospital at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Hospital received Capitation Payment and termination occurred, Hospital shall be paid according to the current contracted Hospital fee-for-service rates.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Hospital shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Hospital agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Hospital.

8.3 TERMINATION PLANS --- Hospital shall have a plan for the orderly termination of services under this Contract. Hospital shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or

termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Hospital acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Hospital shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Hospital acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Hospital shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with Hospital, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Hospital on or about the fifteenth (15^{th}) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Hospital.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Hospital an amount equal to [redacted] of the monthly Capitation Payment (Withhold). CalOptima may adjust Hospital's Capitation Payment on a quarterly basis should the Withhold fall below [redacted] of Hospital's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Hospital. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Hospital as soon as practicable. Capitation may also be adjusted

in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Hospital shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- Hospital has an obligation to report any overpayment identified by Hospital, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Hospital, or of receipt of notice of an overpayment identified by CalOptima. Hospital acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Hospital, CalOptima shall have the right to recover such amounts from Hospital by recoupment or offset from current or future amounts due from CalOptima to Hospital, after giving Hospital notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Hospital to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by Hospital to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.
9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to Hospital's capitation
9.4.6 Payments made by CalOptima that are the financial responsibility of Hospital.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Hospital paid by CalOptima against any funds owed to Hospital by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Hospital additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Hospital any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Hospital.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Health Network Member is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled in the Health Network and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, Hospital is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Health Network Member is actively diagnosed as a hemophilia patient, then on the first of the following month following diagnosis and notification of CalOptima, then the adult Member will be disenrolled from the Health Network and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Hospital is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to PHC is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with PHC and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, PHC is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY --- Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Hospital shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Hospital any material deficits.

10.2 Not Applicable to this Contract.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Hospital's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Hospital accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Hospital copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Hospital copies of current MOUs entered into by CalOptima that are binding on Hospital. Copies of current MOUs entered into by CalOptima that are binding on Hospital may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Hospital interpretation of MOUs entered into by CalOptima that are binding on Hospital. Interpretation of MOUs will identify duties, obligation and responsibilities of Hospital.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Hospital acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Hospital, information and data relating to the performance of Hospital and PHC that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Hospital shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to the CalOptima Medi-Cal Program. Hospital complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES –

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Hospital the financial risk assumed under the Contract by providing to Hospital the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Hospital, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale (“RBRVS”) year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include

sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Hospital the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Hospital sufficient details to allow Hospital to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Hospital, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF HEALTH NETWORK TERMINATION PLANS --- CalOptima shall review and approve Hospital termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Hospital's capitation withhold to Hospital upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Hospital of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply Hospital's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Hospital financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Hospital insolvency. CalOptima shall release to Hospital financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Hospital insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Hospital may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the Health Network ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Hospital fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the PHC in which Hospital participates by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) not having the required amounts and types of financial reserves; (ix) failure to meet Medical Loss Ratio requirements; (x) failure to meet minimum enrollment requirements; (xi) failure to meet quality and/or performance requirements; (xii) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; and (xiii) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Hospital or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Hospital or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Hospital is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for

any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the Hospital's Capitation Payment.

13.1.2.2 Hospital may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust this administrative remedy, including requesting a hearing according to the Policy, before commencing a civil action.

13.1.3 Termination for Cause - Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Hospital may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Hospital shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, Hospital shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of Hospital.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Hospital in the event that membership in the PHC in which Hospital participates falls below five thousand (5,000) total members at any time based upon three (3) month rolling average of Hospital's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Hospital fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should Hospital fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Hospital that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION OR SANCTION FOR TERMINATION OR SANCTION OF THE PHC PARTNER --- This Contract shall terminate upon the termination of the Contract of the other party in the PHC. Notification of termination to any party in the PHC shall constitute notification of termination to all parties in the PHC. CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all parties in the PHC independent of the party in the PHC whose action(s) caused sanctions to be applied by CalOptima.

13.8 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.9 TERMINATION FOR HOSPITAL INSOLVENCY --- If Hospital becomes insolvent, Hospital shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1.

In the event of the filing of a petition for bankruptcy by or against Hospital or a principal Subcontractor, Hospital shall assure that all Hospital's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Hospital until Hospital fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Hospital obligations have been met.

13.10 TERMINATION BY HOSPITAL FOR CAUSE --- Provided that Hospital is not in default hereunder, Hospital may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to Hospital under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to Hospital any such past due payments.

13.11 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW --- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contracts, or (c) required by changes in any requirements

and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Hospital in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Hospital shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.12 PERFORMANCE MEASURE AND PAYMENTS TO HOSPITAL --- CalOptima may establish key performance measures of Hospital to set minimum contract performance thresholds and/or pay financial incentives to Health Networks. CalOptima may take the following actions, at its sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Hospital, terminate this Contract, and establish Capitation Rates and other payments to Hospital.

13.13 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Hospital agrees as follows:

13.13.1 CalOptima reserves the right to require Hospital, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.13.2 CalOptima requires that Hospital Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Hospital terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.14 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, Hospital shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.8 prior to the end date of the Contract term in the event Hospital elects not to participate in any extension period or new contract term.

13.15 Not Applicable to this Contract.

13.16 EXTENSION, RENEWAL, OR MODIFICATION --- Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. Hospital has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF HOSPITAL --- CalOptima and Hospital agree that Hospital and any agents or employees of Hospital, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. Hospital shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a

result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION --- Hospital agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Hospital or Subcontractor; (iii) the merger, reorganization, or consolidation of Hospital or Subcontractor with another entity with respect to which Hospital is not the surviving entity; and/or (iv) a change in the management of Hospital or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Hospital or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Hospital hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Hospital agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the Hospital certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Hospital is unable to certify to any of the statements in this certification, the Hospital shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Hospital knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also

applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Hospital certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Hospital further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Hospital agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION—

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F-1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.16.3.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled “Standard Form-LLL ‘Disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16.3 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires

disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid,

addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: Hospital

_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- Hospital shall ensure that Hospital and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019, THROUGH JUNE 30, 2020.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Contract:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM I

ENTITIES COMPRISING PHYSICIAN-HOSPITAL CONSORTIUM/CONSORTIA

By this Addendum, the undersigned attests that _____,
(Name of Physician)

a California professional medical corporation, which employs or otherwise contracts with physicians licensed to practice medicine in the State of California ("Physician"), and

_____, an acute care hospital ("Hospital"), have
(Name of Hospital)

affiliated to operate as a physician-hospital consortia (“PHC”) for the purposes of providing or arranging for the provision and payment of Covered Services to Members in compliance with the Contract for Health Care Services.

For Hospital:

_____
Signature

_____
Print Name

_____
Title

_____
Date

Contract for Health Care Services

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	-See Transportation-		
Amniocentesis	X		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	X		
Facility component		X	
Birth Control	-See Family Planning-		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
CBAS			**CalOptima (Claims)**
CHDP	-See Pediatric Preventative Services-		
Chemotherapy			
Professional component	X		
Outpatient Facility component		X	
Medication	-See Medication-		
Chiropractic Services	X		

	Physician	Hospital Budget	Other
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services			
Professional component (Other than provided by Dentist)			
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component			
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment	**X**		

	Physician	Hospital Budget	Other
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		X	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	X		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		X	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services			
Acupuncture	X		
Autism Screening	X		
Audiology	X		
Chiropractic	X		
Cochlear Implant	X		
Dental Services			**State**
EPSDT Case Management	X		
Hearing Aid Batteries	X		
In-Home Private Duty Nursing (PDN)	X		
Medical Nutrition Services	X		
Occupational Therapy	X		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	X		
Mental Health – Specialty Outpatient			**OC HCA/ State**
Family Planning (all provider types)			
Professional component	X		
Surgically implanted sterilization devices		X	
IUDs (with or without medication)	X		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	X		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		

	Physician	Hospital Budget	Other
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications		***-See Medication -***	
Home infusion		***-See Medication -***	
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables		***- See Medications -***	
Immunizations		***- See Preventive Services -***	
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room		***- See Emergency Services -***	
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	

	Physician	Hospital Budget	Other
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission			
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Partial Hospitalization Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	

	Physician	Hospital Budget	Other
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient -DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		

	Physician	Hospital Budget	Other
Outpatient Diagnostic Services	*-See Diagnostic Services (Outpatient) -*		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	*- See Medication -*		
Physical Therapy	*- See Rehabilitation -*		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			*VFC (Vaccines for Children Program)*
Administration fee	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	*- See Diagnostic Services -*		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	*- See Long Term Care Services -*		
Short stay	*- See Hospitalization -*		
Speech Therapy	*- See Rehabilitation -*		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated:_____ Signature:_____

Name:_____
(Please type or print)

Title:_____
(Please type or print)

Attachment C
Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____

Signed

_____

Date

ATTACHMENT E
Capitation Rates
Effective July 1, 2019

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Family/Poverty/Child	0 year, Both	[redacted]		
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Low Income Children Program (formerly Healthy Families)	0 year, Both	[redacted]		
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Adult	All Ages Both	[redacted]		
Aged	All Ages, Both	[redacted]		
Disabled	0 - 14 years, Both	[redacted]	[redacted]	
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
ESRD - Family	All ages, Both	[redacted]	[redacted]	[redacted]
ESRD - Poverty	All ages, Both			
ESRD - Child	All ages, Both			
ESRD - Adult	All ages, Both			
ESRD - Aged	All ages, Both			

Aid Code	Age & Gender	Base	Base	Total Cap

Category	Category	Hospital	Physician	Rate
ESRD - Disabled	All ages, Both	[redacted]	[redacted]	[redacted]
ESRD - MCX	All ages, Both			
ESRD - MSI	All ages, Both			
AIDS - Family	All ages, Both	[redacted]	[redacted]	[redacted]
AIDS - Poverty	All ages, Both			
AIDS - Child	All ages, Both			
AIDS - Adult	All ages, Both			
AIDS - Aged	All ages, Both			
AIDS - Disabled	All ages, Both			
AIDS - MCX	All ages, Both			
AIDS - MSI	All ages, Both			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment	[redacted]	[redacted]	[redacted]

Whole Child Model Base Capitation Rates

The following Whole Child Model payment provisions are effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program.

The following base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

	Hospital	Physician	Total Capitation
Whole Child Model	[redacted]	[redacted]	[redacted]

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

ATTACHMENT E–1
Capitation Rates for Adult Expansion Members

Effective July 1, 2019 through June 30, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code	Age & Gender	Base Cap Rate		
Category	Category	Hospital	Physician	Total
Expansion (MCX)	0 - 14 years, Both	[redacted]	[redacted]	[redacted]
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
Expansion (MSI)	0 - 14 years, Both	[redacted]	[redacted]	[redacted]
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least [redacted] of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment F-1 is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

- Payment rates shall be as follows:
  - Physician payment [redacted]
  - Hospital payment [redacted]

ATTACHMENT F-1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
contract grant cooperative agreement loan loan guarantee loan insurance	bid/offer/application initial award post-award	initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify: _____

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

AMENDMENT I TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT I TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of October 1, 2019 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital wish to enter into this amendment to restate the Division of Financial Responsibilities and Formulary Medical Supplies, provide the requirements for the distribution of Ground Emergency Medical Transportation (GEMT)/QAF supplemental payment and provide information and requirements related to supplemental payments for certain home health agency services.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility" shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I.

2. Attachment C, "Formulary Medical Supplies" shall be deleted in its entirety and replaced with the attached Attachment C – Amendment I.

3. Attachment E-2, "Distribution of GEMT QAF Funding", shall be added to the Contract and is attached hereto.

4. Attachment E-3, "Supplemental Payment for Home Health Agency Services", shall be added to the Contract and is attached hereto.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services
Amendment I

ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)	**X**				
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				

	Physician		Hospital		Other
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				

	Physician		Hospital		Other
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				

	Physician		Hospital		Other
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				

	Physician		Hospital		Other
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component	**X**				
Outpatient facility component	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***

	Physician		Hospital		Other
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***					
[2] ***Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.***					

ATTACHMENT C

Amendment I

Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

Respiratory Items

- Inhaler Assist Devices
- Nasal Aspirator
- Peak Flow Meters, Non-Electric

Contraceptive Items

- Condoms
- Diaphragms

Diabetic Supplies

- Blood Glucose Monitors (excludes Continuous Glucose Monitors which are covered as DME)
- Insulin Syringes
- Lancets
- Lancet Auto Injectors
- Blood Glucose Test Strips
- Urine Test Strips
- Alcohol Pads

ATTACHMENT E-2
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Hospital shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and Hospital, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. Hospital must reimburse Eligible Non-Contracted Providers a differential totaling up to XXX that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to Hospital, and Hospital agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay Hospital an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. “Eligible Non-Contracted Provider” shall mean a Provider who is not contracted with Hospital to provide GEMT services or a Provider who is contracted with Hospital for transportation services, but not contracted with Hospital to provide GEMT services to CalOptima Medi-Cal members.

    b. “Qualifying Services” shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. Hospital shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to XXX for Qualifying Services furnished by Eligible Non-Contracted Providers. Hospital is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the Hospital within one year after the date of service.

3. Hospital shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. Hospital is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a XX% administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. Hospital and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. Hospital shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, Hospital shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to Hospital based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. Hospital shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to Hospital by means of a Notice to this Contract.

ATTACHMENT E-3

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (X%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by fifty percent (xx%) effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, Hospital will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the Hospital's reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

AMENDMENT II TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT II TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2020 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend the Contract to identify the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the coronavirus known as COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-4, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E-4

MEDI-CAL RATE ENHANCEMENT

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). Pursuant to the action taken by CalOptima Board of Directors on April 2, 2020, in anticipation of a fluctuation in utilization by Medi-Cal members and the need for flexible services due to COVID-19, CalOptima amends the current Medi-Cal capitation base rate levels set forth in Attachment E to increase them by [redacted] for the period commencing April, 1 2020 and continuing through, and including, June 30, 2020.

AMENDMENT III TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT III TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of July 1, 2020, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend the Contract to extend the term of the Contract, administer directed payments per CalOptima policy and procedure and revise the capitation rates.

NOW, THEREFORE, the parties agree as follows:

1. Section 2.6.18. of the Contract, and any references thereto, shall be renumbered as Section 2.6.19, and new Section 2.6.18 shall be added to the Contract as follows:

   "2.6.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and Hospital shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-2, by Hospital to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to Hospital."

2. Article 15, Section 15.1 shall be deleted in its entirety and replaced with the following:

   "15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE JUNE 30, 2019 THROUGH JUNE 30, 2021."

3. ATTACHMENT E shall be deleted and replaced with the attached ATTACHMENT E- AMENDMENT III "Capitation Rates".

4. ATTACHMENT E-1 shall be deleted and replaced with the attached ATTACHMENT E- 1 - AMENDMENT III "Capitation Rates for Adult Expansion Members".

5. ATTACHMENT E-2 "Distribution of GEMT QAF Funding" shall be deleted and replaced with the attached ATTACHMENT E-2 – AMENDMENT III, "Distribution of GEMT QAF Funding".

6. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and

effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT III

Capitation Rates

Effective July 1, 2020

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

ATTACHMENT E-1 – AMENDMENT III

Capitation Rates for Adult Expansion Members

Effective July 1, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Hospital.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Hospital to remit the portion of the difference attributed to Hospital.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Hospital.

Aid Code Category	Age & Gender Category	**Base Hospital**	**Base Physician**	**Total Cap Rate**
Expansion	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	**Physician**	**Total Capitation**
Supplemental OB Delivery Care Payment			

ATTACHMENT E-2 – AMENDMENT III

Distribution of GEMT QAF Funding

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Hospital shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and Hospital, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. Hospital must reimburse Eligible Non-Contracted Providers a differential totaling up to $xx.00 that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to Hospital, and Hospital agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay Hospital an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. “Eligible Non-Contracted Provider” shall mean a Provider who is not contracted with Hospital to provide GEMT services or a Provider who is contracted with Hospital for transportation services, but not contracted with Hospital to provide GEMT services to CalOptima Medi-Cal members.

    b. “Qualifying Services” shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. Hospital shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to $xx for Qualifying Services furnished by Eligible Non-Contracted Providers. Hospital is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the Hospital within one year after the date of service.

3. Hospital shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. Hospital is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a x% administrative fee calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. Hospital and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. Hospital shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, Hospital shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to Hospital based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. Hospital shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to Hospital by means of a Notice to this Contract.

10. Notwithstanding other provisions of this Attachment E-2, effective July 1, 2020, CalOptima and Hospital shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program pursuant to Section 2.6.18 of the Contract.

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital wish to enter into this amendment to revise the Division of Financial Responsibilities, revise the Termination for Convenience provision as well as modify language as appropriate to align with all Health Care Services contracts.

NOW, THEREFORE, the parties agree as follows:

1. Section 1.16, "CalOptima Regulators", shall be deleted in its entirety and replaced with the following:

   "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforce applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Hospital, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Health Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

2. Section 1.22, "Community Liaison" or "CL", shall be deleted and intentionally left blank.

3. Section 1.23, "Community Liaison Program" or "CLP", shall be deleted and intentionally left blank.

4. Section 1.55, "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)", shall be deleted in its entirety and replaced with the following:

   "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

5. Section 1.64, "Memorandum/Memoranda of Understanding" or "MOU", shall be deleted in its entirety and replaced with the following:

   "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements,

including but not limited to the Coordination and Provision of Public Health Care Services Contract.

6. Section 1.83, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)", shall be deleted in its entirety and replaced with the following:

"Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol."

7. Section 1.94, "Subcontract", shall be deleted in its entirety and replaced with the following:

"Subcontract" means a written agreement entered into by the Hospital with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Hospital specifically related to fulfilling Hospital's obligations to CalOptima under the terms of this Contract.

8. Section 1.95, "Subcontractor", shall be deleted in its entirety and replaced with the following:

"Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Hospital. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with Hospital to perform any administrative function or service for Hospital specifically related to fulfilling Hospital's obligations to CalOptima under the terms of this Contract."

9. Section 2.3.2 shall be deleted in its entirety and replaced with the following:

"Commercial General Liability/Commercial Automobile Liability:
Hospital shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Hospital's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract."

10. Section 2.3.8 shall be deleted in its entirety and replaced with the following:

"Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Hospital shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Hospital shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request."

11. Section 2.6.12, "Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments", shall be deleted in its entirety and replaced with the following:

"Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in PHC's provider network, PHC shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy."

12. Section 2.6.13, "Family Planning Provider Payments", shall be deleted in its entirety and replaced with the following:

"Family Planning Provider Payments – PHC shall reimburse non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. PHC shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy."

13. Section 2.6.14, "Sexually Transmitted Disease Treatment Payments", shall be deleted in its entirety and replaced with the following:

"Sexually Transmitted Disease Treatment Payments – PHC shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. PHC may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to PHC along with billing information."

14. Section 2.6.15, "HIV Testing and Counseling Payments", shall be deleted in its entirety and replaced with the following:

"HIV Testing and Counseling Payments - PHC shall reimburse local health departments and non-contracting family planning providers at no less than [redacted] of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. PHC shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to PHC."

15. Section 3.4, "CALOPTIMA LOGO", shall be deleted in its entirety and replaced with the following:

"CALOPTIMA LOGO --- Hospital shall not display the CalOptima logo on any of Hospital's written communication to Members without prior written approval by CalOptima."

16. Section 3.9, "SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"SUBCONTRACTS --- Hospital may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Hospital is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Hospital is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. Hospital shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI

and CMS requirements for reporting information about Offshore Subcontracts. Hospital shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, Hospital shall require all Subcontracts contain the following:"

17. Section 3.9.2 shall be deleted in its entirety and replaced with the following:

"An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;"

18. Section 3.9.7 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;"

19. Section 3.9.8 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;"

20. Section 3.9.10 shall be deleted in its entirety and replaced with the following:

"An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;"

21. Section 3.9.12 shall be deleted in its entirety and replaced with the following:

"An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;"

22. Section 3.9.20 shall be deleted in its entirety and replaced with the following:

"An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Hospital delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement);"

23. Section 3.9.25 shall be deleted in its entirety and replaced with the following:

"An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and"

24. Section 3.9.26 shall be added as follows:

"Subcontractor's agreement to provide Hospital with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request."

25. Section 3.17, "MEDICAL AND ADMINISTRATIVE RECORDS", shall be deleted in its entirety and replaced with the following:

"MEDICAL AND ADMINISTRATIVE RECORDS --- Hospital shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). Hospital shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site."

26. Section 3.19.1 shall be deleted in its entirety and replaced with the following:

"Through the end of the records retention period specified in Section 3.18, Hospital shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Hospital's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years."

27. Section 3.24, "FRAUD AND ABUSE REPORTING", shall be deleted in its entirety and replaced with the following:

"FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or Physician's employees, within five (5) working days of the date when Physician first becomes aware of or is on notice of such activity."

28. Section 3.24.2 shall be deleted in its entirety and replaced with the following:

"Hospital shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program."

29. Section 3.28, "COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Hospital shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Hospital's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations."

30. Section 3.30, "COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s))", shall be deleted in its entirety and replaced with the following:

"COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- Hospital agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. Hospital agrees to require Subcontractors to comply with applicable requirements of such MOUs."

31. Section 3.42, "OBLIGATIONS UNDER PRIOR CONTRACT", shall be deleted in its entirety and replaced with the following:

"OBLIGATIONS UNDER PRIOR CONTRACT --- Hospital acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Hospital shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between Hospital and CalOptima pursuant to which Hospital agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members."

32. Section 3.45, "HOSPITAL SUBCONTRACTS", shall be deleted in its entirety and replaced with the following:

"HOSPITAL SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Hospital shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. Hospital shall ensure that all Subcontracts are in writing and require that the Hospital and its Subcontractors:"

33. Section 4.2, "EMERGENCY CARE", shall be deleted in its entirety and replaced with the following:

"EMERGENCY CARE --- Hospital shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). Hospital is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week."

34. Section 5.1, "HOSPITAL GEOGRAPHIC DISTRIBUTION", shall be deleted in its entirety and replaced with the following:

"HOSPITAL GEOGRAPHIC DISTRIBUTION --- Hospital shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Hospital shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence."

35. Section 6.4, "QUALITY IMPROVEMENT PROGRAM", shall be deleted in its entirety and replaced with the following:

"QUALITY IMPROVEMENT PROGRAM --- PHC shall participate and cooperate in CalOptima's Quality Improvement Program. PHC shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. PHC shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). PHC shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. PHC shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:"

36. Section 10.7, "MOU AVAILABILITY", shall be deleted in its entirety and replaced with the following:

"MOU AVAILABILITY--- CalOptima shall provide or make available for Hospital copies of current MOUs entered into by CalOptima that are binding on Hospital within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on Hospital may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website."

37. Section 10.10, "PROVIDER COMPLAINT SYSTEM", shall be deleted in its entirety and replaced with the following:

"PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and Hospital shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Hospital complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system."

38. Section 13.1, "SANCTIONS AND TERMINATIONS FOR CAUSE," shall be deleted in its entirety and replaced with the following:

"SANCTIONS AND TERMINATIONS FOR CAUSE --- If Hospital fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the PHC by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation

Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:"

39. Section 13.8, "TERMINATION FOR CONVENIENCE", shall be deleted in its entirety and replaced with the following:

"TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination."

40. Attachment A, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment VI.

41. Attachment E, "Capitation Rates", shall be deleted and replaced with the attached Attachment E – Amendment VI.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A – AMENDMENT VI

CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)			**X**		
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies by a non-pharmacy provider (excluding medications)	**X**				
Attachment C contraceptive items/supplies when provided by CalOptima PBM Pharmacy					***CalOptima (Pharmacy)***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy					***CalOptima Pharmacy***
--All other Medical Supplies[1]	**X**				
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***CalOptima Pharmacy***
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM					***CalOptima Pharmacy***
Outpatient Medication dispensed by Non-Pharmacy Providers					***CalOptima (Claims)***
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)					***DHCS***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		

	Physician		Hospital		Other
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC/HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9					***CalOptima (Pharmacy & Claims)'s***
Enteral Nutrition	**X**				
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**				
Other Nutrition Products	**X**				

	Physician		Hospital		Other
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine (inclusive of Medi-Cal administration fee)	**X**				**-**
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				

	Physician		Hospital		Other
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***

	Physician		Hospital		Other
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation *					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
** CCS specific services are paid per Article 9.*					
[1] Services are the responsibility of MTP if provided under the MTP program.					
[2] Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.					

ATTACHMENT E – AMENDMENT VI

Capitation Rates

Effective January 1, 2021

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child / Adult	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
SPD	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			
ESRD	Child / Adult			
	SPD			
	Expansion			
AIDS	Child / Adult			
	SPD			
	Expansion			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Whole Child Model Base Capitation Rates

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Whole Child Model	0 year, Both			
	1 - 14 years, Both			
	15 -18 years, Female			
	15 - 18 years, Male			
	19 - 39 years, Female			
	19 - 39 years, Male			
	40 - 64 years, Both			
	65+ years, Both			

The base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Supplemental OB Delivery Care Payment

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Funding for PCC

In addition to those amounts described above, Physician shall receive [redacted] per WCM or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by their Aid Code Category, for all age groups. WCM member is identified by their WCM Eligible condition as determined by the local WCM Program. Physician shall only receive PCC funding for a Member with an SPD aid code category or a WCM-eligible condition as determined by the County, not both. Members with a WCM Eligible Condition shall prevail over SPD members when determining payment.

Physician acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event Physician fails to comply with the requirements as defined by the CalOptima Profile and Policy. Physician acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician's future PCC Payments in the event CalOptima determines that Physician has not complied with the Profile requirements.

AMENDMENT VI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2021 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, [redacted] ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and Hospital desire to amend the Contract to include the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. ATTACHMENT E-5 "MEDI-CAL RATE ENHANCMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and [redacted] have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E-5

MEDI-CAL RATE ENHANCEMENT

For the period from January 1, 2021, through June 30, 2021, the base physician and base hospital capitation rates set forth in Attachment E – Amendment V for the Child/Adult and SPD aid code categories shall be increased by [redacted] This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E – Amendment V, or the Adult Expansion Member capitation rates in Attachment E-1 Amendment III.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

34. Consider Reallocating Intergovernmental Transfer (IGT) Funds and Approving a Grant Agreement for Whole-Person Care Housing Navigation and Supportive Services

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Authorize reallocation of up to $640,000 in IGTs 1, 3, 4 and 6 to Orange County Health Care Agency's (OCHCA) Whole-Person Care (WPC) pilot for Housing Navigation and Supportive Services (HNSS) for CalOptima Medi-Cal members; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a Grant Agreement with OCHCA to provide $640,000 in grant funds for the County's WPC pilot for HNSS provided to CalOptima Medi-Cal members enrolled in WPC.

Background

On October 24, 2016, the County of Orange (County) received approval from the Department of Health Care Services (DHCS) for a five-year program to implement the WPC pilot. The Orange County WPC pilot is administered by the OCHCA. DHCS and the Centers for Medicare & Medicaid Services (CMS) agreed to a one-year extension of the WPC pilot, ending on December 31, 2021. OCHCA's WPC extension agreement with DHCS is expected to be considered by the Orange County Board of Supervisors on May 25, 2021. OCHCA has continued to provide key WPC services, including HNSS, in 2021.

WPC HNSS-contracted vendors are reimbursed by County on a per member per month basis. HNSS include, but are not limited to the following:

- Aiding WPC clients with document and income readiness
- Matching WPC clients with housing vouchers to appropriate housing resources and providing navigation services to those who do not have housing vouchers
- Acting as a liaison in collaboration with and between WPC clients and landlords
- Assisting with the housing application process and securing letters of support as needed
- Coaching WPC clients for meetings with potential property managers, and preparing them for placement and arranging transportation to potential housing placement opportunities
- Ensuring that WPC clients become residents after housing placement
- Arranging for utilities to be turned on
- Educating WPC clients on housekeeping, "good neighbor," and independent living skills
- Linking WPC clients to peer mentoring and other sustainability services for ongoing support to further ensure housing sustainability

Discussion

Based on anticipated voucher availability, OCHCA expects at least 469 WPC-enrolled CalOptima members to be eligible to receive HNSS in 2021. Based on experience, OCHCA advises that, on

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average, a person receives eight months of HNSS services. As a result, some members began receiving these services in 2020 and continued into 2021. Approximately $440,000 in expenditures for HNSS services were incurred between January 1, 2021 and February 28, 2021. Based on actual and projected utilization of HNSS services, potential rollover funds from the 2020 WPC pilot year, anticipated County funding and state match for 2021, OCHCA anticipates a shortfall of $1.1 million to $1.5 million. OCHCA has asked for CalOptima's support to help bridge this gap.

CalOptima staff recommends reallocation of remaining unspent funds from IGTs 1, 3, 4 and 6, totaling $640,000, for a grant to County. The grant would be used to reimburse 50% of the County's costs for WPC HNSS provided to qualifying CalOptima members, Reimbursement would not be available for CalOptima members enrolled in the Health Homes Program (HHP). Staff recommends making the grant effective June 1, 2021, and through December 31, 2021, subject to availability of IGT funds. Five prior IGT initiatives were completed, leaving approximately $166,332 available for reallocation for this purpose as follows: IGT 1 ($45,000), IGT 3 ($250) and IGT 4 ($121,082). Additionally, CalOptima reviewed other remaining IGT 1–7 allocations for possible reallocations to support WPC HNSS for our members. Staff recommends reallocation of $473,668 from IGT 6 IGT Program Administration funding for this purpose. See Attachment 2 for more information on IGTs 1, 3, 4 and 6 funds available for reallocation.

If approved, this grant will improve access to WPC HNSS for CalOptima members experiencing homelessness. Further, this funding would support maintenance of the existing WPC HNSS infrastructure pending CalOptima's potential implementation of similar services under the DHCS California Advancing and Innovating Medi-Cal (CalAIM) In Lieu of Services (ILOS) proposal, subject to DHCS and CalOptima Board approval. Staff will return to the Board for actions related to CalAIM implementation, including ILOS, at a later date.

Fiscal Impact

The recommended action to authorize reallocation of up to $640,000 in IGT 1, 3, 4 and 6 funds to provide grant funding to OCHCA for HNSS to CalOptima Medi-Cal members enrolled in the WPC pilot has no fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Reallocation of IGTs 1, 3, 4 and 6 funds will support CalOptima members enrolled in WPC to obtain and retain housing and, thereby, support improved health outcomes. In addition, and subject to DHCS and CalOptima's Board approval, it will help maintain and sustain the HNSS infrastructure through 2021 to ensure continuity and availability of similar ILOS services beginning in 2022.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by This Recommended Action
2. IGT Reallocation Source Summary
3. Grant Agreement

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Orange County Health Care Agency	405 W 5th Street	Sana Ana	CA	92701

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IGT Reallocation Background and Source Summary

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions.

IGTs 1 through 7 funds were established based on retrospective payments for prior rate range years and were made available to CalOptima for the purpose of providing enhanced/additional benefits to existing CalOptima Medi-Cal beneficiaries, as represented to the Center for Medicare & Medicaid Services. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries. For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs.

Source Summary

The below table reflects initiatives which have been completed leaving a remaining balance or for which funding is no longer required. The table also notes the focus area submitted to DHCS and CMS.

IGT #	Funds Received	Focus Area- Submission to DHCS/CMS	IGT Projects	Latest Board Allocation Approval Date	Available to Reallocate (as of 1/31/2021)
1	9/2012	Enhance provider reimbursement; Strengthen delivery system	Depression Screenings	12/1/2016	**$45,000**
3	9/2014	Services related to care coordination and case management for CalOptima members	Recuperative Care: Phase 2	10/1/2015	**$250**
4	10/2015 3/2016	Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives	Provider Portal Communications & Interconnectivity	12/1/2016	**$43,490**
			Member Health Homes Program		**$72,192**
			UCI Observation Stay Payment Pilot		**$5,400**
6	9/2017 5/2018	Board approved programs/initiatives which support CalOptima's mission and benefit Orange County's Medi-Cal beneficiaries	Program Administration	9/6/2018	**$473,668**
			Total Funds for Potential Reallocation:		**$640,000**

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GRANT AGREEMENT

BETWEEN

CALOPTIMA AND

THE COUNTY OF ORANGE

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GRANT AGREEMENT BETWEEN
CALOPTIMA AND
THE COUNTY OF ORANGE

THIS GRANT AGREEMENT (Grant Agreement) is made and entered into as of June 1, 2021 by and between Orange County Health Authority, dba CalOptima, a public agency and the county organized health system for the County of Orange, California (CalOptima), and the County of Orange, through its division, the Orange County Health Care Agency, a political subdivision of the State of California (County). CalOptima and County are sometimes referred to herein individually as "Party" and collectively as the "Parties".

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into an Agreement with the State of California, Department of Health Care Services (DHCS Agreement), pursuant to which CalOptima is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. California's Section 1115(a) Medicaid Waiver Renewal, entitled Medi-Cal 2020, was approved by the Centers for Medicare and Medicaid Services on December 30, 2015 and included funding for a Whole Person Care (WPC) Pilot Program.

D. The California Department of Health Care Services (DHCS) published a Request for Application (RFA) relating to the WPC Pilot Program on May 16, 2016. In response to the RFA, County acting as the Lead Entity in County of Orange submitted an application for the WPC Pilot Program. The RFA required the participation of a managed care plan. CalOptima, as a Managed Care Plan provider in County of Orange agreed to collaborate in the WPC Pilot Program as a partner and submitted a letter of participation that was included in County's application for the WPC Pilot Program.

E. County, as a Lead Entity, and DHCS entered into a five-year contract for the WPC Pilot Program, Contract No. 16-14184-OR-30 (DHCS/County Contract) which takes a patient-centered approach to coordinate physical, behavioral health, and social services with the overall goal to improve health and well-being of Medi-Cal members experiencing homelessness. The WPC Pilot Program connects the individuals to services in the community that may include, but are not limited to, recuperative care, 1:1 Personal Care Coordinator, Housing Navigation and Supportive Services, and mental health/substance use disorder treatment, as appropriate.

F. WPC was set to expire December 31, 2020. DHCS and Center for Medicare & Medicaid Services (CMS) agreed to a one-year extension of the WPC Pilot, ending December 31, 2021.

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Although the DHCS/County Contract extension of the WPC Pilot has not been finalized, its WPC Pilot continues to provide key WPC services, including Housing Navigation and Supportive Services. Based on estimated roll-over funds from 2020 WPC Pilot year, County anticipates a short-fall of $1.1-$1.5 million, all of which is still being finalized for Housing Navigation and Supportive Services. County asked CalOptima, as its WPC Collaborative Partner in the WPC Pilot Program, to help bridge the gap.

G. CalOptima agreed to and shall reallocate $640,000.00 of Intergovernmental Transfer (IGT) 1, 3, 4 and 6 funds to pay County 50% of County's WPC Housing Navigation and Supportive Services costs, from June 1, 2021 through December 31, 2021, on a percentage of cost reimbursement basis for Housing Navigation and Supportive Services provided to qualifying CalOptima Medi-Cal members who are not enrolled in CalOptima's Health Homes Program.

NOW, THEREFORE, in recognition of the Recitals above, and the mutual covenants, benefits, and promises contained herein, the receipt of which the Parties hereby acknowledge, County and CalOptima do hereby agree as follows:

I. COUNTY OBLIGATIONS

1.1 **County Responsibilities.** County agrees to provide or arrange for the competent and effective provision of Housing Navigation and Supportive Services, as described in Attachment A, attached hereto and incorporated herein by this reference.

1.2 **Equal Opportunity.** County shall be, and state that it is, an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other agreement or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of County's commitments as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

1.3 **Non-Discrimination.** During the performance of this Grant Agreement, County shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, creed, color, national origin, ancestry, physical or mental disability (including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), medical condition (including cancer), marital status, age (over 40), sexual orientation, or the use of family and medical care leave and pregnancy disability leave. County shall ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. County shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 *et seq*.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Grant Agreement by reference and made a part hereof as if set forth in full. County shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

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County shall not discriminate against members or eligible beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

1.4 **Limitations on Subcontracting and Assignment**. The experience, knowledge, capability, and reputation of County, its directors and employees were a substantial inducement for CalOptima to enter into this Grant Agreement. County shall be fully responsible to CalOptima for the acts and omissions of its subcontractor as it is for the acts and omissions of persons directly employed. Nothing contained in this Grant Agreement shall create any contractual relationship between any subcontractor and CalOptima. All persons engaged in the work will be considered employees of County. CalOptima will deal directly with and make all payments to County.

1.5 **Subcontracts.** County shall assure that all subcontracts are in writing and include any requirements of this Grant Agreement that are appropriate to the service or activity and assure that the Subcontract shall not terminate legal liability of County under this Grant Agreement.

1.6 **Excluded Providers**. County shall ensure that no subcontractor receiving funds provided under this Grant Agreement is or has been suspended or excluded from participation in Federal and/or State health care programs.

II. COMPENSATION

2.1 **County Compensation.** Compensation to County under this Grant Agreement will be the payments set forth in Attachment B, incorporated herein by this reference, which shall be payment in full.

2.2 **Payments.** County agrees to submit invoices, along with any supporting materials to CalOptima in such format as CalOptima may direct. No payment under this Grant Agreement shall be made except pursuant to a properly formatted invoice accompanied by all applicable supporting materials.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **County Certification, Accreditation and License Requirements.** County warrants and represents that County and its professional personnel currently have, and during the term of this Grant Agreement shall maintain, any necessary certification, permits, accreditation and licensure required by the State of California, federal government including CMS, or any applicable local

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government or agency, for all services furnished under this Grant Agreement. Upon request, County shall provide copies of such information as acceptable to CalOptima.

3.2 **Compliance with Applicable Law**. In carrying out the Housing Navigation and Supportive Services, County shall comply with state and federal laws and regulations applicable to the Housing Navigation and Supportive Services and DHCS/County Contract and CalOptima policies to the extent applicable to this Grant Agreement.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records.** County shall keep such books and records as shall be necessary relating to the services performed under this Grant Agreement. All financial records shall be maintained in accordance with generally accepted accounting principles ("GAAP"). Records generated in the course of carrying out this Grant Agreement shall be maintained for five (5) years from the final date of the Grant Agreement period, or the date of the completion of any audits related to this Grant Agreement, whichever is later. County shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Grant Agreement. County shall pay all duplication and postage costs associated with any Audits and/or reviews necessary to ensure compliance with this Grant Agreement or CalOptima's regulatory requirements.

4.2 **Final Report and Audit**. Within sixty (60) calendar days after the end of this Grant Agreement, County shall provide CalOptima with a final report and attestation. This final report and attestation shall consist of the following: (i) a narrative summarizing the services provided by County during the term of this Grant Agreement and the outcomes thereof, and (ii) an attestation by the WPC Project Manager certifying that the report of expenditures is accurate and complete. County shall refund to CalOptima any amounts that are found to not have been utilized in accordance with the requirements of Attachment A.

V. INSURANCE AND INDEMNIFICATION

5.1 **County Comprehensive General Liability ("CGL")/Automobile Liability**. County at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers, employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the carrying out the project, b) the use of any property of the County, and c) Grant Activities performed in connection with this Grant Agreement, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.2 **Insurer Ratings**. All above insurance shall be provided by an insurer:

(a) rated by Best's with a rating of B or better; and

(b) admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and

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listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.3 **Captive Risk Retention Group/Self Insured.** Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.4 **Cancellation or Material Change.** The County shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Grant Agreement.

5.5 **Certificates of Insurance**. Except to the extent waived pursuant to Section 5.3, prior to execution of this Grant Agreement, County shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.6 **Indemnification.**

5.6.1 **General Indemnification**. County shall defend, indemnify and hold harmless CalOptima, its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) which are related to or arise out of the negligent or willful performance or non-performance by the County, of any functions, duties or obligations of County arising under this Grant Agreement. Neither termination of this Grant Agreement nor completion of the acts to be performed under this Grant Agreement shall release County from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.6.2 **Funding Indemnification**. Notwithstanding Section 5.6.1, the Parties acknowledge that the indemnification obligations in this section 5.6.2 apply to the subject matter addressed herein. County acknowledges that CalOptima is using Intergovernmental Transfer Funds to fund the amounts set forth in Attachment B ("IGT Funds"). County will without delay defend, hold harmless and indemnify CalOptima from and against any and all claims and liabilities that result from recapturing, recoupment or repayment of the IGT Funds (including reasonable attorneys' fees and reasonable expenses) and any amounts for fines, assessments, sanctions and/or civil penalties assessed or imposed, due to a disallowance of the IGT Funds by DHCS and/or the Centers for Medicare and Medicaid Services ("CMS"). Such claims and liabilities

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include, without limitation, attorneys' fees and reasonable expenses incurred to respond to informal or formal communications (*e.g.*, subpoenas) from DHCS, CMS and/or other regulatory or law enforcement agencies. Acceptance by CalOptima of any insurance certificates and endorsements required under the Grant Agreement does not relieve County from liability under the indemnification obligation herein. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

5.7 **Notification of Claims.** CalOptima agrees to promptly notify County of any claims or demands which arise and for which indemnification hereunder is sought.

5.8 **Termination.** The terms of this Article V shall survive the termination of this Grant Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement.** This Grant Agreement will commence on June 1, 2021 and will remain in effect up to and including December 31, 2021, unless earlier terminated as permitted in this Grant Agreement.

6.2 **Termination.** If County fails to fulfill any of its duties and obligations under this Grant Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Grant Agreement, CalOptima may terminate this Agreement for cause pursuant to this Article VI.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Grant Agreement, CalOptima may terminate this Grant Agreement for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2 of this Article. County may appeal CalOptima's decision to terminate the Grant Agreement for cause by filing a complaint pursuant to CalOptima Policies. County shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima Policies, for any and all County complaints, before commencing any civil action. CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Grant Agreement.

6.4 **CalOptima's Right to Terminate Grant Agreement for Convenience.** Nothing herein will be construed as limiting the right of CalOptima to terminate this Grant Agreement for convenience without cause by giving County at least thirty (30) calendar days prior notice to the effective date of such termination.

6.5 **Automatic Termination.** This Grant Agreement shall terminate automatically upon termination of the DHCS/County Contract, or upon termination of the Medi-Cal 2020 Section 1115(a) Medicaid Waiver.

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6.6 **Bankruptcy.** CalOptima or County may terminate this Grant Agreement with thirty (30) calendar days written notice to the other Party in the event a petition is filed in a court of record jurisdiction to declare either party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or if a trustee in bankruptcy or a receiver is appointed for such party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) calendar days thereof.

6.7 **Recovery upon Termination**. In the event that this Grant Agreement is terminated pursuant to this section VI, County shall repay to CalOptima any amounts previously paid to County for services under this Grant Agreement that have not been provided as of the effective date of that termination. Such repayment shall be made within thirty (30) days of the effective date of the termination.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language.** CalOptima has the right to final interpretation of the Grant Agreement language when disputes arise. County has the right to appeal disputes concerning Grant Agreement language to CalOptima.

7.2 **Waiver.** The waiver by either Party of a breach or violation of any provision of this Grant Agreement will not operate as or be construed to be a waiver of any subsequent breach thereof.

7.3 **Assignment.** Neither this Grant Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by County without the prior written consent of CalOptima. CalOptima may assign this Grant Agreement and its rights, interests and benefits hereunder to any entity which has at least majority control of CalOptima or to any entity whose financial solvency has been approved by County, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Grant Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

7.4 **Independent Parties.** Grantee acknowledges that it is, at all times, acting as an independent contractor under this Grant Agreement and, except as specifically provided herein, not as an agent, employee, or partner of CalOptima. Grantee agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits.

7.5 **Integration of Entire Agreement.** This Grant Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Grant Agreement. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Grant Agreement, which are not expressly set forth in this Grant Agreement are null and void and of no further force or effect. All Attachments to this Grant Agreement are considered part of this Grant Agreement and are hereby incorporated herein.

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7.6 **Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.7 **Amendment.** CalOptima may amend this Grant Agreement immediately upon written notice to County, only to the extent necessary, in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Grant Agreement shall be effective only upon mutual, written agreement of the Parties.

7.8 **Independent Agreement.** Nothing in this Grant Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to CalOptima members. No monies paid under this Grant Agreement may be used for the provision of services that are payable under a different Grant Agreement between the Parties, or for any other purpose beyond the Housing Navigation and Supportive Services identified in Attachment A.

7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Omissions.** In the event that either Party hereto discovers any material omission in the provisions of this Grant Agreement which such Party believes is essential to the successful performance of this Grant Agreement, said Party may so inform the other Party in writing, and the Parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Grant Agreement.

7.11 **Choice of Law.** This Grant Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties hereto consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.12 **Force Majeure.** Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Grant Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes.

7.13 **Headings.** The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

7.14 **Debarment Certification.** By signing this Grant Agreement, the Grantee agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

7.14.1 By signing this Grant Agreement, the Grantee certifies to the best of its knowledge and belief, that it and its principals:

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(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal or state department or agency;

(b) Have not within a three-year period preceding this Grant Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or agreement under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subsection 1(b) of this Section 7.14;

(d) Have not within a three-year period preceding this Grant Agreement had one or more public transactions (Federal, State or local) terminated for cause or default;

(e) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(f) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7.14.2 If County is unable to certify to any of the statements in this certification, County shall submit an explanation to CalOptima.

7.14.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

7.14.4 If County knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Grant Agreement for cause or default.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to County in the event of any default or breach by CalOptima, or for any amount that may become due to County, or any obligation under the terms of this Grant Agreement.

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7.16 **Time of Essence**. Time is of the essence in the performance of this Grant Agreement.

7.17 **Authority to Execute**. The persons executing this Grant Agreement on behalf of the Parties warrant that they are duly authorized to execute this Grant Agreement, and that by executing this Grant Agreement, the Parties are formally bound.

7.18 **Notices.** All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: County
Attention: Contract Services
405 West 5th Street
Suite 600
Santa Ana, CA 92701

[SIGNATURES FOLLOW ON NEXT PAGE]

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VIII: SIGNATURES

IN WITNESS WHEREOF, CalOptima and County have executed this Grant Agreement, to be effective the date first written above:

FOR COUNTY:	FOR CALOPTIMA
_____	_____
Signature	Signature
_____	Richard Sanchez
Print Name	Print Name
_____	Chief Executive Officer
Title	Title
_____	_____
Date	Date

Approved as to Form:
County Counsel
County of Orange, California

By: _____

Date:_____

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ATTACHMENT A

WPC HOUSING NAVIGATION AND SUPPORTIVE SERVICES

I. WPC HOUSING NAVIGATION AND SUPPORTIVE SERVICES:

"Housing Navigation Services" means the process by which homeless individuals that have entered the Coordinated Entry System (CES), which is the County's system that connects these individuals to the appropriate services and housing interventions in the community, are provided with ongoing engagement, document collection, and case management services in order to facilitate a match to an appropriate house resource. In the context of CES, outreach workers, case managers, and other providers that service the homeless, may provide housing navigation services. "Supportive Services" means services that may assist homeless participants in the transition from the streets or shelters into permanent or permanent supportive housing, and that assist persons with living successfully in housing. To the extent that services are not covered under the CalOptima Medi-Cal program, Housing Navigation and Supportive Services may include, but are not necessarily limited to the following:

a. Aiding WPC clients with document and income readiness such as helping obtain identification card, social security card, social security/disability income applications, etc.;
b. Matching WPC clients with a voucher to appropriate housing resources or providing navigation services to those who do not have housing vouchers;
c. Acting as a liaison in collaboration with and between WPC client and landlord;
d. Transporting or arranging for transportation of WPC clients to potential housing placement opportunities;
e. Assisting with the housing application process;
f. Securing reasonable letters of support as needed;
g. Ensuring that WPC client becomes a resident after housing placement;
h. Arranging for utilities to be turned on;
i. Educating WPC clients on housekeeping issues and "good neighbor" issues such as maintenance, community living, and independent living skills;
j. Coaching WPC clients in order to have successful interactions when meeting with potential property managers, and to prepare them for placement; and
k. Linking WPC clients to peer mentoring and other sustainability services for ongoing support in an effort to further ensure housing sustainability.

County warrants that Housing Navigation and Supportive Services provided hereunder shall be in compliance with all requirements of the DHCS/County Contract.

II. REFERRALS FOR HOUSING NAVIGATION AND SUPPORTIVE SERVICES:

The criteria for approval of Member referrals to Housing Navigation and Supportive Services Providers shall be according to WPC Program criteria for Housing Navigation and Supportive Services, which shall be determined by County prior to the effective date of this Grant Amendment. Housing Navigation and Supportive Services continue until it is determined that the individual no longer requires the services.

III. CRITERIA FOR REIMBURSEMENT:

In the event County refers and pays for the provision of Housing Navigation and Supportive Services for qualifying CalOptima Medi-Cal members who are not enrolled in CalOptima's Health Homes Program, County may seek reimbursement from CalOptima for such Housing Navigation and Supportive Services subject to the terms and conditions below and this Grant Agreement.

a. County shall have agreements in place with Housing Navigation and Supportive Services providers.
b. County shall pay the Housing Navigation and Supportive Services providers for services rendered. CalOptima shall not have liability to Housing Navigation and Supportive Services providers for any services.
c. Funding for Housing Navigation and Supportive Services is limited to those funds remaining in the Housing Navigation and Supportive Services Fund, which consists of those funds allocated from Intergovernmental Transfer Funds for Housing Navigation and Supportive Services. No payments may be made under this Grant Agreement for Housing Navigation and Supportive Services other than from the Housing Navigation and Supportive Services Fund.

IV. LIMIT ON FUNDING AVAILABLE FOR REIMBURSEMENT:

CalOptima's funding shall be limited to the unspent CalOptima Intergovernmental Transfer ("IGT") dollars allocated for Housing Navigation and Supportive Services approved by the CalOptima Board of Directors. Reimbursement shall be available for Housing Navigation and Supportive Services for CalOptima Members who are not enrolled in CalOptima's Health Homes Program, regardless of whether the CalOptima member is assigned to CalOptima Direct, to a CalOptima Shared Risk Health Network, to a CalOptima HMO Health Network, or to a CalOptima Physician-Hospital Consortium. Regardless of the quantity or volume of Housing Navigation and Supportive Services provided by County, in no event will CalOptima's obligations exceed said remaining CalOptima IGT dollars specifically allocated for Housing Navigation and Supportive Services, payable at a rate of 50% of the Direct Housing Navigation and Supportive Services costs incurred by County per CalOptima Member receiving such services for the month invoiced. Qualifying for reimbursement for Housing Navigation and Supportive Services, however, does not make CalOptima responsible for services that are the financial responsibility of a Health Network.

ATTACHMENT B

PAYMENT FOR SERVICES

I. HOUSING NAVIGATION AND SUPPORTIVE SERVICES FUND---For purposes of this Attachment B, "Housing Navigation and Supportive Services Fund" shall consist of those funds allocated from Intergovernmental Transfer Funds by the CalOptima Board of Directors for Housing Navigation and Supportive Services.

II. REIMBURSEMENT—To the extent that adequate funds remain in the Housing Navigation and Supportive Services Fund, CalOptima shall reimburse County at the rate of 50% of the Direct Housing Navigation and Supportive Services costs incurred by County, from June 1, 2021 through December 31, 2021, for Housing Navigation and Supportive Services provided to CalOptima Members who meet WPC Pilot Program criteria and who are not enrolled in CalOptima's Health Homes Program, as reflected in supporting documentation attached to an invoice. County shall accept this rate as payment in full from CalOptima. If the funds in the Housing Navigation and Supportive Services Fund are exhausted, CalOptima shall have no further obligation to compensate County for Housing Navigation and Supportive Services.

III. INVOICE SUBMISSION---Invoices for Housing Navigation and Supportive Services, along with all required supporting documentation, shall be submitted to CalOptima, in a format provided by CalOptima, to the following address:

CalOptima
Attn: Accounts Payable
505 City Parkway West
Orange, CA 92868

IV. DIRECT HOUSING NAVIGATION AND SUPPORTIVE SERVICES COSTS---For purposes of this Grant Agreement, "Direct Housing Navigation and Supportive Services Costs" mean those amounts actually paid to a Housing Navigation and Supportive Services provider for Housing Navigation and Supportive Services provided to a homeless CalOptima Medi-Cal Member who, during the duration of such services, meets WPC Pilot Program criteria for such services and is not enrolled in CalOptima's Health Homes Program.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Approving CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Model of Care Approach

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Approve CalOptima's proposed California Advancing and Innovating Medi-Cal (CalAIM) Model of Care (MOC) approach, effective January 1, 2022, for submission to the Department of Health Care Services (DHCS), including utilizing CalOptima's health networks as Enhanced Care Management (ECM) Providers and the launch of four In Lieu of Services (ILOS), listed below.

Background

On January 8, 2021, DHCS released the revised CalAIM proposal that takes a whole-person care approach (incorporating both clinical and non-clinical services) led by Managed Care Plans (MCP) with the goal of improving health outcomes for Medi-Cal members. CalAIM initiatives span over five years beginning January 1, 2022. The two key initiatives with a January 1, 2022, go-live are ECM and ILOS. Both require an implementation plan, called the Model of Care (MOC), to be submitted to DHCS by July 1, 2021. The MOC will describe how CalOptima plans to design, implement, and administer ECM services and ILOS to its eligible members. An important component of the MOC will be the transition of members currently participating in the CalOptima-led Health Homes program (HHP) and/or the County-led Whole Person Care (WPC) pilot. CalOptima's proposed approach to CalAIM ECM and ILOS is intended to build upon infrastructure created through the HHP and the WPC pilot, in alignment with DHCS's goals. Final regulatory guidance and associated materials will not be made available to plans until the end of May 2021. For this reason, staff are seeking Board approval on the approach for both ECM and ILOS and will return to the Board following DHCS feedback on CalOptima's proposed MOC to seek approval of final policies and related DHCS deliverables.

Discussion

ECM is the coordination of both clinical and non-clinical services and ILOS are flexible wraparound services provided as a substitute for, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge. ILOS are optional for MCPs to offer and members to receive. CalOptima will implement these initiatives not only for members currently enrolled in and receiving services via the HHP or the WPC pilot, but also for all MCP members who meet the Phase 1 "Populations of Focus" eligibility requirements, as defined by DHCS.

DHCS is developing definitions for the CalAIM Populations of Focus through an iterative process. Using the current eligibility parameters for each group, and subject to DHCS revision, CalOptima's ECM-eligible population on January 1, 2022 may include:

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Populations of Focus	Projected Members as of 5/12/21
Homeless	3,302
High utilizers	12,037
Serious Mental Illness (SMI) and Substance Use Disorder (SUD)	18,277
Total	**33,616**

Estimates for ILOS utilization are not available at this time, since multiple factors impact the uptake of these services.

All WPC- or HHP-enrolled members will automatically be approved for ECM and reassessed within six months after the transition. Upon reassessment, CalOptima and its ECM providers will ensure appropriate levels of case management, non-duplication of services, evaluation of members' current needs and updates to members' plans of care to improve health outcomes.

ECM
To meet CalAIM requirements, CalOptima staff recommends leveraging the existing HHP model and proposes to transition its contracted health networks, currently acting as community-based care management entities (CB-CMEs), to serve as ECM Providers. CalOptima staff also proposes to delegate ECM services, including accompaniment services, which DHCS indicates is part of ECM services, to its contracted health networks for their assigned members. CalOptima's approach to transition the current CB-CMEs to ECM Providers will allow its members to be able to maintain relationships with their current providers, to continue receiving services and allow the ECM Providers to easily integrate ECM into their delivery system by building upon HHP infrastructure.

ILOS
To ensure a seamless transition for members, providers and community, staff recommends offering the following ILOS for Phase 1, beginning January 1, 2022, which are currently being provided to CalOptima members either through WPC or HHP:

1) Housing Transition Navigation Services: assistance for members to obtain housing, but does not constitute a housing deposit or room and board;
2) Housing Deposits: assistance with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board;
3) Housing Tenancy and Sustaining Services: assistance with maintaining a safe and stable tenancy for individuals once housing is secured; and
4) Recuperative Care (Medical Respite short-term residential care for members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

In following DHCS guidance to build provider capacity, CalOptima is awaiting draft ILOS rate information from DHCS to inform future ILOS vendor contracting. Staff will return to the Board to seek authority to execute ILOS contracts, as appropriate. Concurrently, CalOptima is planning for additional ILOS services to launch later in 2022 or 2023 through surveying its community partners in addition to reviewing its own membership data to identify services that might be most beneficial for its members. Staff will return to the Board with recommendations on future ILOS to pursue later this year.

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Prior to launch, CalOptima will conduct a readiness assessment for all ECM and ILOS contracted providers to ensure their readiness to provide the required services beginning January 1, 2022. Staff will return to the Board in late summer to seek approval on the selection of and funding for a consulting service to complete the readiness assessments. In parallel to the completion of the readiness assessment, CalOptima will provide training to all ECM and ILOS contracted providers' staff to ensure they build appropriate expertise and skills to serve members through this initiative.
To ensure the success of new CalAIM initiatives, DHCS plans to provide some start-up incentive funding to MCPs in the first two years for ECM and ILOS in order to build appropriate and sustainable capacity and improve quality performance. CalOptima anticipates receiving further information about these incentives later this year. Staff will return to the Board to request approval of the provider payment methodology for the mandatory ECM benefit and optional ILOS, later this year.

Through these CalAIM implementation efforts, CalOptima intends to minimize health disparity, increase member independence, and improve health outcomes.

Fiscal Impact
The proposed Fiscal Year 2021-22 Operating Budget, pending Board approval, assumes that CalOptima will take on financial risk for the mandatory ECM benefit and optional ILOS effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral. However, given the limited information available at this time, projected costs for these changes are difficult to predict. CalOptima will continue to advocate with DHCS to ensure these changes are adequately funded and monitor utilization and expenses related to the new benefit and services.

Rationale for Recommendation
The recommended action will enable CalOptima to successfully transition the HHP and the WPC pilot into CalAIM ECM and ILOS, effective January 1, 2022, for the required CalAIM Populations of Focus.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Management Report April 1, 2021, CalOptima Board of Directors, California Advancing and Innovating Medi-Cal (CalAIM)
3. Department of Health Care Services CalAIM Proposal
4. CalOptima ILOS Fact Sheet
5. CalAIM Presentation, June 3, 2021

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
County of Orange				
Name	**Address**	**City**	**State**	**Zip Code**
Orange County Health Care Agency	405 W 5th Street	Sana Ana	CA	92701

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CalOptima

Better. Together.

California Advancing and Innovating Medi-Cal (CalAIM)

Board of Directors Meeting

April 1, 2021

Rachel Selleck, Executive Director, Public Affairs

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Background

Whole Person Care
(2016–21)
- Lead Entity: County of Orange
- Services:
  - Housing Navigation and Sustainability (includes housing deposits)
  - Recuperative Care

Health Homes Program
(2020–21)
- Lead Entity: CalOptima
- Services:
  - Comprehensive Care Management*
  - Housing Navigation and Sustainability

California Advancing & Innovating Medi-Cal (CalAIM)
(2022–27)
- Target Implementation Phase 1: January 2022
- Lead Entity: CalOptima
- Services:
  - Enhanced Care Management**
  - Phase 1 In Lieu of Services (ILOS):
    - Housing Transition Navigation Services
    - Housing Tenancy and Sustaining Services
    - Housing Deposits
    - Recuperative Care

*** Comprehensive Care Management:** Care management addressing primarily clinical needs

**** Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

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Note: Concurrently planning for Phase 2 ILOS services to launch in July 2022.

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Background (cont.)

- CalAIM Enhanced Care Management (ECM) benefit intensifies care management and builds on current Whole Person Care (WPC) pilot and Health Homes Program (HHP) for high-need Medi-Cal beneficiaries

- January 2021: Department of Health Care Services (DHCS) released revised CalAIM proposal

- Expands Medi-Cal Managed Care Plans' responsibilities and provides opportunities for enhanced care

Primary Goals of CalAIM

- Improve member and provider experience
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation

Sources: DHCS CalAIM site: www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

CalAIM Proposal: www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-02172021.pdf

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CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

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Enhanced Care Management (ECM)

- Implement a single, intensive and comprehensive ECM benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Build upon current WPC and HHP delivery systems
- Use phased implementation approach

Date	Population
January 2022	Existing WPC/HHP target populations
July 2022	Additional target populations

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ECM Target Populations

- Children and youth with complex conditions
- Individuals experiencing chronic homelessness with complex conditions
- High health care system utilizers
- Nursing facility residents
- Individuals at risk for institutionalization who are either eligible for long-term care or have co-occurring chronic conditions
- Individuals transitioning from incarceration

Note: WPC and HHP members overlap within these target populations; ECM target populations are subject to change, per DHCS guidance

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CalOptima's ECM Proposal

- To align with CalAIM expectations of integrating WPC and HHP under ECM:
  - Leverage HHP Community-Based Care Management Entities (CB-CMEs) to serve as ECM providers to ensure continuity of care
    - Delegate ECM to health networks as they act as CB-CME for HHP
- Allows members to stay with their health network and minimizes care disruption
- **Funding**: Anticipate State funding

In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

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CalOptima's ILOS Proposal

- To maintain continuity of care, CalOptima (as a carve-out) to offer the following ILOS services currently provided under WPC and HHP (Phase 1):
  - Housing Transition Navigation Services** (WPC, HHP)
  - Housing Tenancy and Sustaining Services** (WPC, HHP)
  - Housing Deposits (WPC)
  - Recuperative Care (Medical Respite) (WPC)
- **Service Providers**: Maintain current providers (through Letters of Agreement or contracts) while RFPs are developed
- **Funding**: IGT/Reserve monies (no anticipated State funding) until savings are realized

** Currently delegated to health networks through HHP

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Next Steps

April 2021	May 2021	June 2021	July 2021
Provide Overview to CalOptima Board	Present Implementation Proposal to Other Stakeholders	Present Final Plan to CalOptima Board	Submit Deliverables to DHCS

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

State of California—Health and Human Services Agency
Department of Health Care Services

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

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1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

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developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

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sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

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state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological testing, when clinically indicated to evaluate a mental health condition;
c) Outpatient services for the purposes of monitoring drug therapy;
d) Psychiatric consultation; and,
e) Outpatient laboratory, drugs, supplies and supplements (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;
- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools

- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities

- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

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6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

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Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

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Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

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Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

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LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

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Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A	
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

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Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

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Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

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which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

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member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

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- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

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significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

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Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

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Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

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Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

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- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

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or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

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- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

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        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

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254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

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described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

California Advancing and Innovating Medi-Cal (CalAIM) In Lieu of Services Fact Sheet

Background

The Whole Person Care (WPC) pilots and Health Homes Program (HHP) built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of In Lieu of Services (ILOS) will make a statewide offering of these critical interventions for Medi-Cal beneficiaries. The Department of Health Care Services (DHCS) is proposing to implement ILOS, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay.

According to federal Medicaid program rules, ILOS are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An ILOS can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the ILOS; and
- The ILOS are authorized and identified in the state's Medi-Cal managed care plan (MCP) contracts.

MCPs will develop a network of providers that have the expertise and capacity regarding specific types of services.

DHCS is proposing to include the following 14 distinct services as ILOS under Medi-Cal managed care. Each service will have defined eligible populations, code sets, potential providers, restrictions and limitations:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

In order to be equipped with the required MLTSS and housing infrastructure, the DHCS must use its ability to provide MCPs with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and ILOS services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

To maintain continuity of care, CalOptima is considering offering services currently provided under WPC and HHP during initial implementation. Those four proposed ILOS are Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services and Recuperative Care. Each is explained further below.

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Housing Transition/Navigation Services

- Housing Transition/Navigation Services assist beneficiaries with obtaining housing and include:
  - » Conducting a tenant screening and housing assessment that identifies the participant's needs, preferences and barriers related to successful tenancy
  - » Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal
  - » Searching for housing and presenting options
  - » Assisting with:
    - ◦ Securing housing, including the completion of housing applications and securing required documentation
    - ◦ Requests for reasonable accommodation
    - ◦ Arranging for and supporting the move
    - ◦ Benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process.
  - » Identifying and securing available resources to assist with
    - ◦ Subsidizing rent and matching available rental subsidy resources to members
    - ◦ Covering expenses if included in the housing support plan
  - » Landlord education and engagement
  - » Ensuring that the living environment is safe and ready for move-in
  - » Communicating and advocating on behalf of the client with landlords
  - » Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized
  - » Identifying, coordinating, securing or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day
  - » Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility
- The services provided:
  - » Should be based on individualized assessment needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.
  - » Should use best practices for clients who are experiencing homelessness and who have complex health, disability and/or behavioral health conditions
  - » May involve coordination with other entities to ensure the individual has access to supports needed for successful tenancy
  - » Do not include the provision of room and board or payment or rental costs
- For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems (CES), homeless services authorities, public housing authorities, and other operators of local rental subsidies

Eligibility Criteria:[1]

Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the Housing and Urban Development (HUD) definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria.

Restrictions and Limitations:

- Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.
- Members who meet the eligibility requirements should also be assessed for ECM and Housing and Tenancy Supportive Services (if provided in their county)

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Housing Deposits

- Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as:
  - » Security deposits required to obtain a lease on an apartment or home
  - » Set-up fees/deposits for utilities or service access and utility arrearages
  - » First month coverage of utilities, including but not limited to telephone gas, electricity, heating and water
  - » First month's and last month's rent as required by a landlord for occupancy
  - » Services necessary for the individuals' health and safety, such as pest eradication and one-time cleaning prior to occupancy
  - » Goods, such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home, such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc.
- The services provided should utilize best practices for clients who are experiencing homelessness and have complex health, disability and/or behavioral health conditions, including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

Eligibility Criteria:[1]

Individuals who:

- Received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition Navigation Services; or
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the HUD definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness or are determined to be at risk of experiencing homelessness; or
- Meet the State's No Place Like Home definition of "at risk of chronic homelessness"

Restrictions and Limitations:

- Housing Deposits are an allowable ILOS if they are:
  - » Available once in an individual's lifetime
  - » Can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt CalOptima is expected to make a good faith effort to review information available to determine if individual has previously received services
  - » Identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense
  - » Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner

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Housing Tenancy and Sustaining Services

Housing tenancy and sustaining services are aimed at maintaining safe and stable tenancy for individuals once housing is secured and include:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources; education and training on the role, rights and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized
- Health and safety visits, including unit habitability inspections
- Coordinating with the landlord and case management provider to address identified issues that could impact housing stability and the tenant to for modifications to their housing support and crisis plan on a regular basis
- Assistance with:
  - » Resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action
  - » Benefits advocacy, including assistance related to SSI eligibility and the SSI application process.
  - » The annual housing recertification process
  - » Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized

The services provided:

- Should be based on individualized assessment needs and documented in the individualized housing support plan.
- May involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.
- Do not include the provision of room and board or payment of rental costs.

Eligibility Criteria:[1]

Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the Housing and Urban Development (HUD) definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria.

Restrictions and Limitations:

- Available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed
- Available for a single duration in an individual's lifetime
- Can be approved one additional time with appropriate documentation regarding success on a second attempt
- Services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance
- Although not required, many individuals will have also received Housing Transition/Navigation Services in conjunction with this service

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
- Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports
- Clients who meet the eligibility requirements for Housing Tenancy and Sustaining Services should also be assessed for ECM and may have received Housing Transition/Navigation services (if provided in the county)

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Recuperative Care

- Recuperative care, or medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.
- Recuperative care includes but is not limited to the following services:
  - » Limited or short-term assistance with Instrumental Activities of Daily Living and/or Activities of Daily Living
  - » Coordination of transportation to post-discharge appointments
  - » Connection to any other ongoing services an individual may require, including mental health and substance use disorder services
  - » Support in accessing benefits and housing
  - » Gaining stability with case management relationships and programs

Eligibility Criteria:

Individuals who are at risk of hospitalization or are post-hospitalization and live alone with no informal supports or face housing insecurity or have housing that would jeopardize their health and safety without modification

Restrictions and Limitations:

- Necessary to achieve or maintain medical stability and prevent hospital admission or readmission
- Not more than 90 days in continuous duration
- Does not include funding for building modification or building rehabilitation
- Providing other housing ILOS is encouraged in conjunction with recuperative care and on-site in the recuperative care facilities.

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include but are not limited to:
  - » Interim housing facilities with additional on-site support
  - » Shelter beds with additional on-site support
  - » Converted homes with additional on-site support
  - » County directly operated or contracted recuperative care facilities
- CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained.

**Subject to change as per DHCS guidance*

Endnotes

[1] For an exhaustive list of all eligibility requirements, please reference the most current DHCS CalAIM Proposal.

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CalAIM

California Advancing and Innovating Medi-Cal

June 3, 2021

Rachel Selleck, Executive Director, Public Affairs
Tracy Hitzeman, Executive Director, Clinical Operations

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Better. Together.

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Background

- January 2021: Department of Health Care Services (DHCS) released revised California Advancing and Innovating Medi-Cal (CalAIM) proposal

- Expands Medi-Cal Managed Care Plans' responsibilities

- Addresses longstanding challenges in Medi-Cal
  - High cost of services for a small number with high needs
  - Significant variation and complexity in service delivery

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Background (Cont.)

Whole Person Care (WPC) (2016–21)
Lead Entity: County of Orange
Services:
- Housing Navigation and Sustainability (includes housing deposits)
- Recuperative Care

Health Homes Program (HHP) (2020–21)
Lead Entity: CalOptima
Services:
- Comprehensive Care Management*
- Housing Navigation and Sustainability

California Advancing and Innovating Medi-Cal (CalAIM) (2022–27)
Lead Entity: CalOptima
Services:
- Enhanced Care Management**
- Phase 1 In Lieu of Services (ILOS):
  1) Housing Transition Navigation Services
  2) Housing Tenancy and Sustaining Services
  3) Housing Deposits
  4) Recuperative Care

Phase 1 Implementation: January 2022

***Comprehensive Care Management:** Care management addressing primarily clinical needs

****Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

Note: CalOptima is concurrently planning for Phase 2 ILOS.

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CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

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Enhanced Care Management (ECM)

- Creates a single, intensive and comprehensive benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Builds upon existing Health Homes Program (HHP) delivery system infrastructure
- Uses a phased implementation approach based on DHCS-defined Populations of Focus

DHCS Preliminary Timeline

Implementation Date	Population of Focus	WPC	HHP
January 1, 2022	Homeless* Adult High Utilizers Adults with Serious Mental Illness/Substance Use Disorder (SMI/SUD)	Yes Yes Yes	Yes Yes Yes
January 1, 2023	Members transitioning from incarceration Members eligible for Long-Term Care (LTC) or at risk of institutionalization Nursing facility residents transitioning to community	No No No	No No No
July 1, 2023	Child/Youth (High Utilizers; Serious Emotional Disturbance (SED)/high psychosis risk; California Children's Services (CCS) or Whole Child Model (WCM); involvement/history of involvement with Child Welfare; and transitioning from incarceration)	No	No

* To avoid disruption in service, children/youth currently served by HHP/WPC will transition into ECM on January 1, 2022, and be reassessed.

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WPC/HHP Member Transition to CalAIM

- All WPC/HHP enrolled members will automatically be approved for ECM
  - Reassessment required within six months
    - Ensure appropriate level of case management (ECM, Complex Case Management, Basic Case Management) and non-duplication of services
    - Evaluate member's current needs
    - Update member's plan of care

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DHCS Population of Focus: Homeless

Person experiencing homelessness*

+

Complex physical/behavioral/developmental health

+

Unable to self-manage health successfully

+

Health outcomes would improve with service coordination

OR

High-cost services would decrease with coordination

* New HUD homelessness definition: Lacks adequate nighttime residence, primary residence is public place not used for habitation, living in a shelter, exiting an institution to homelessness, will lose housing in next 14 days, unaccompanied youth, homeless families with children, victims fleeing domestic violence

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DHCS Population of Focus: High Utilizers

Frequent use of Emergency Department* could be avoided with better outpatient care/treatment adherence

OR

Frequent unplanned hospitalizations** could be avoided with better outpatient care/treatment adherence

OR

Frequent Skilled Nursing Facility stays*** could be avoided with better outpatient care/treatment adherence

* 6 or more Emergency Department visits within 12 months
** 2 or more unplanned hospital admissions within 12 months
***2 or more skilled nursing facility stays (does not include custodial care/Long-Term Care)

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DHCS Population of Focus: SMI/SUD

County Specialty Mental Health/Drug Medi-Cal eligible

+

Complex social factor influencing health

+

At least one of the below

At high risk for institutionalization	Overdose/at risk of overdose
Pregnant or parenting	At risk of suicide
ER visit for SUD/alcohol use	Admission for SUD/alcohol use
Use of crisis services/ER/urgent care/hospital for primary care	

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CalOptima ECM-Eligible Populations

Populations of Focus*	Medi-Cal Only	OneCare/Medi-Medi	Total
Homeless	2,863	439	**3,302**
High Utilizer	11,432	605	**12,037**
SMI/SUD	16,819	1,458	**18,277**
Total	**31,114**	**2,502**	**33,616**

*DHCS established criteria, subject to change

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CalAIM ECM Outreach Plan

- Designed to meet the unique needs of each Population of Focus
  - Homeless population outreach
    - Personal Care Coordinators offer services at shelters, navigation centers and recuperative care facilities
    - Clinical Field Team/Homeless Response Team are in-person contacts
  - High utilizer outreach
    - During discharge planning
    - At Interdisciplinary Care Team meetings
    - Multimodal approach (telephonic, e-communication, in-person)
  - SMI/SUD outreach
    - At Interdisciplinary Care Team meetings
    - Offer services where members receive care

In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

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CalOptima's Proposed Approach

- Build upon WPC and HHP infrastructure
- ECM/ILOS providers will need to pass readiness assessment

	ECM	ILOS
Contracting	CalOptima to contract with HHP Community-Based Care Management Entities (CB-CMEs)	CalOptima to contract directly with WPC and HHP ILOS providers
Funding	State funded	No initial funding expected from State

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CalOptima's Proposed Approach

- Build upon WPC and HHP infrastructure
- ECM/ILOS providers will need to pass readiness assessment

	ECM	ILOS
Contracting	CalOptima to contract with HHP Community-Based Care Management Entities (CB-CMEs)	CalOptima to contract directly with WPC and HHP ILOS providers
Funding	State funded	No initial funding expected from State*

*DHCS anticipates funding through savings due to reduction in utilization of covered State Plan Services

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Providers Readiness Assessment

- CalOptima will collaborate with ECM and ILOS providers to ensure readiness on the following, as applicable, but not limited to:
  - WPC and HHP transition plan
  - Model of Care expectations
  - Network adequacy
  - Provider capacity
  - Policies and procedures compliance

Proposed Timeline	
Summer 2021	Request for Proposal and Consultant selection
Fall 2021	Conduct Readiness Assessment

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Provider Training

- Provider training will be conducted either via in-person sessions, webinars and/or calls
- Training shall encompass:
  - Program overview
  - Member care plan, care coordination and care transitions expectations
  - Community resources, referral process, as well as operational and condition-specific trainings
  - Special populations
  - Social determinants of health
  - Motivational interviewing, trauma-informed care
  - Health literacy assessment and information sharing

Next Steps

2021–22	Actions
June 2021	Seek CalOptima Board approval for DHCS submission
July 2021	Submit completed Model of Care (MOC) Template Part 1 to DHCS
Late Summer	Obtain DHCS approval of completed MOC Template Part 1
October 2021	Submit completed MOC Template Part 2 (provider capacity and contract templates) deliverable due to DHCS
Fall 2021	Hold stakeholder planning event
Fall 2021	Complete readiness assessments and provider training
December 2021	Sunset WPC and HHP
January 2022	Go-live with ECM and Phase 1 ILOS

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Board of Directors Meeting
June 3, 2021

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

On April 22, 2021, the OneCare Connect Member Advisory Committee (OCC MAC) held its bi-monthly meeting via teleconference using GoTo Meeting Webinar technology.

The OCC MAC approved its FY 2020-2021 meeting schedule and approved a recommendation from their nominations ad hoc committee to submit a slate of candidates to the Board for appointment.

Richard Sanchez, Chief Executive Officer, announced Emily Fonda, M.D. had been promoted to Chief Medical Officer. He also discussed how the strategic planning team lead by Rachel Selleck, Executive Director, Public Affairs would be reviewing the feedback received from all the Board advisory committees to provide the OCC MAC with another opportunity to provide feedback. He also noted that CalOptima and the Orange County Health Care Agency continue to work collaboratively to distribute vaccines to those most vulnerable in Orange County.

Ladan Khamseh, Chief Operating Officer, updated the OCC MAC members on the current status of a draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. She noted the policy would include draft language that is intended to define the criteria and provided the process for health networks to submit requests for contract model changes. Ms. Khamseh also provided an update on the Qualified Medicare Beneficiary annual outreach to members.

Emily Fonda, M.D., Chief Medical Officer, discussed the COVID-19 vaccination efforts and the incentives that are being provided to members for receiving COVID-19 vaccines. Dr. Fonda also addressed the myths that were circulating about the vaccines.

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback they have received on the FY 2020-2022 Strategic Plan that was presented at the advisory committees' joint meeting March 11, 2021. OCC MAC members provided additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories during the meeting.

The committee also received an update on CalAIM from Pallavi Patel, Director, Process Excellence, and a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
June 3, 2021

Whole-Child Model Family Advisory Committee Update

On April 27, 2021, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its bi-monthly meeting via teleconference using GoTo Meeting Webinar technology.

The WCM FAC approved its FY 2020-2021 meeting schedule and approved a recommendation from the nominations ad hoc committee to forward the recommended slate of candidates to the Board to fill seats that will expire on June 30, 2021. WCM FAC members also considered recommending the addition of an Orange County Health Care Agency (OCHCA) seat to the committee and requested that staff to submit the necessary paperwork for the creation of this seat.

Ladan Khamseh, Chief Operating Officer, announced Emily Fonda, M.D., had been promoted to Chief Medical Officer. Ms. Khamseh updated the members on the Qualified Medicare Beneficiary annual outreach program and on the status of a draft policy intended to address health network model changes that had been discussed at the August 2020 Board meeting.

Emily Fonda, M.D., Chief Medical Officer, provided an update on the current status of the COVID-19 vaccination efforts and discussed the incentives that are being provided to members for receiving the COVID-19 vaccine. Dr. Fonda also discussed the myths that were circulating throughout the community about the vaccines.

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Debra Kegel, Director, Strategic Development, and Claudia Magee, Manager, Strategic Development, on feedback received on the FY 2020-2022 Strategic Plan at the advisory committee's joint meeting on March 11, 2021. WCM FAC provided additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories during the meeting.

Kristin Gericke, Director, Pharmacy Management, provided an update on the delay of the Medi-Cal Rx transition to Magellan Health Care. Pallavi Patel, Director, Process Excellence, provided an update on the upcoming CalAIM program and Jackie Mark, Sr. Policy Advisor, Government Affairs, provided the committee with a Federal and State Legislative update.

WCM FAC member Maura Byron, who is also the Executive Director of the Family Support Network provided the committee with a presentation on how the Family Support Network assists Orange County families by offering resources and advocacy for families and children with social, emotional, intellectual, and physical needs.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

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Provider Advisory Committee Update
Board of Directors Meeting
June 3, 2021

On May 13, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

PAC members approved their FY 2021-2022 meeting schedule and also approved the proposed slate of candidates as recommended by the nominations ad hoc committee to fill upcoming PAC vacancies. PAC requested that staff prepare the necessary paperwork to forward appointment recommendations to the Board for seats expiring on June 30, 2021.

Richard Sanchez, Chief Executive Officer, provided an update and announced that Marie Jeannis has been named CalOptima's Executive Director of Quality and Population Health Management. Mr. Sanchez also discussed the Report to the Community that is posted on the CalOptima website and reflects on the past year as a way to honor the incredible work of our providers on behalf of CalOptima members. He also shared that CalOptima would be hosting a virtual CalAIM stakeholder meeting. He also invited PAC members to share with their organizations that CalOptima would be hosting a COVID-19 vaccine event in the parking lot on May 15, 2021 and noted that appointments were still available to receive vaccines.

Ladan Khamseh, Chief Operating Officer, updated the PAC members on the postponement of two draft health network policies. The health network reporting policy was postponed to allow time for staff to include more detailed information. Separately, the draft policy addressing requests by health networks for model changes was being delayed until after consideration by the Board's delivery system Ad Hoc. Staff is currently making updates to the Health Network reporting policy and plans to resubmit it to the Board for consideration at its June 3, 2021 meeting.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress, noting that 31,000 gift cards have been sent to members as an incentive for getting vaccinated and that over 879 gift cards have been given to members experiencing homelessness for obtaining vaccines. Dr. Fonda also noted that over 200,000 text messages have been sent out to publicize the vaccine event at CalOptima on May 15, 2021 as well as messenger videos, clergy videos and a Public Broadcasting Service (PBS) broadcast to spread the word throughout Orange County.

Rachel Selleck, Executive Director, Public Affairs, provided a California Advancing and Innovating Medi-Cal (CalAIM) presentation. She noted that an overview had been presented at the April Board meeting and in May to the advisory committees. A recommended plan will be presented to the Board at its June meeting with proposed submission deliverables to the Department of Health Care Services (DHCS) due on or before July 1, 2021. She also noted that a response from DHCS is anticipated late Summer on CalOptima's CalAIM submission.

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PAC also received a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Member Advisory Committee Update
Board of Directors Meeting
June 3, 2021

On May 13, 2021, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

MAC members approved their FY 2021-2022 meeting schedule, increasing the MAC's meeting frequency from 6 bi-monthly meetings to 10 monthly meetings. The MAC also approved a proposed slate of candidates to fill seats expiring on June 30, 2021 as recommended by the MAC nominations ad hoc committee, and requested that staff forward the recommendations to the Board for its consideration in appointing the recommended candidates.

Richard Sanchez, Chief Executive Officer, announced that Marie Jeannis has been named CalOptima's Executive Director of Quality and Population Health Management. Mr. Sanchez also discussed the Report to the Community that is posted on the CalOptima website and reflects on the past year as a way to honor the incredible work of our providers on behalf of CalOptima members. Mr. Sanchez also shared that CalOptima would be hosting a virtual CalAIM stakeholder meeting on May 14, 2021. He also invited the MAC to share with their organizations that CalOptima would be hosting a COVID-19 vaccine event on May 15, 2021 and noted that appointments were still available to receive these vaccines.

Ladan Khamseh, Chief Operating Officer, updated the MAC members on the postponement of two draft health network policies. The health network reporting policy was postponed to allow time for staff to include more detailed information. Separately, the draft policy addressing requests by health networks for model changes was being delayed until after consideration by the Board's delivery system Ad Hoc. Staff is currently making updates to the health network reporting policy and plans to resubmit it to the Board for consideration at its June 3, 2021 meeting.

Emily Fonda, M.D. Chief Medical Officer, provided a comprehensive COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress. Dr. Fonda noted that over 31,000 gift cards have been sent to members as an incentive for getting vaccinated. This includes 900 gift cards have been given to members experiencing homelessness. Dr. Fonda updated the MAC on the over 200,000 text messages that have been sent out to publicize the vaccine event at CalOptima on May 15, 2021 as well as messenger videos, clergy videos and a Public Broadcasting Service (PBS) broadcast to spread the word throughout Orange County.

Rachel Selleck, Executive Director, Public Affairs, provided a California Advancing and Innovating Medi-Cal (CalAIM) presentation. She noted that this overview had been presented to the Board at its April meeting as well as to all of the Board's advisory committees. A recommended plan will be presented to the Board at its June 3, 2021 meeting with proposed submission deliverables to the Department of Health Care Services (DHCS) due on or before July 1, 2021. She also noted that CalOptima is anticipating a response from DHCS late Summer on this submission.

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MAC also received a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's activities.

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