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

MARCH 6, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

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

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_S4FH4FANRkKLMYz2hTdxxQ to Join the Meeting.
Webinar ID: **862 8091 4979**
Passcode: **830513** -- Webinar instructions are provided below.

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

1. Federal Lobbyist Update (Verbal)

MANAGEMENT REPORTS

2. Chief Executive Officer Report

3. Covered California Update

ADVISORY COMMITTEE UPDATES

4. Member Advisory Committee and Provider Advisory Committee Updates

PUBLIC COMMENTS

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

CONSENT CALENDAR

5. Minutes
   a. Approve Minutes of the February 6, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the November 21, 2024 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

6. Approve New CalOptima Health Policy EE. 1145: Prospective Health Network

7. Approve New CalOptima Health PACE Policy PA.2003: PACE Palliative Care

8. Authorize Contract Amendment Related to CalOptima Health Key Operational Vendor Health Management Systems, Inc.

9. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024

10. Approve Actions Related to a Contract with the National Opinion Research Center to Conduct a Member and Population Health Needs Assessment

11. Ratify a Sole Source Contract with Axis Technology for Data Masking Professional Services

12. Receive and File:
    a. January 2025 Financial Summary
    b. Compliance Report
    c. Government Affairs Reports
    d. CalOptima Health Community Outreach and Program Summary
    e. Board Approved Initiatives Report – Quarter Three

REPORTS/DISCUSSION ITEMS

13. Authorize Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

14. Approve Actions Related to the Street Medicine Program City Expansion

15. Authorize Actions Related to Equity and Practice Transformation Program

16. Approve Actions Related to Professional, Ancillary, Hospital, and Health Network Contract Amendments and Templates for Covered California

CLOSED SESSION

CS-1. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California

CS-2. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code § 54956.9(d)(2): 1 Case.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on March 6, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_S4FH4FANRkKLMYz2hTdxxQ

To **Join** this webinar:
https://us06web.zoom.us/s/86280914979?pwd=rvLKKKRNnKnwFisQKMu6TRbjbVG9WG.1

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+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
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+1 720 707 2699 US (Denver)
+1 253 205 0468 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 558 8656 US (New York)
+1 646 931 3860 US
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+1 301 715 8592 US (Washington DC)
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Webinar ID: 862 8091 4979
Passcode: 830513
International numbers available: https://us06web.zoom.us/u/kdkjkd4zpP

PRESENTATIONS/INTRODUCTIONS

1. Federal Lobbyist Update (Verbal)

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MEMORANDUM

DATE:	February 28, 2025
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — March 6, 2025, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. FY 2025–26 Proposed State Budget Released

Gov. Gavin Newsom recently released his Fiscal Year (FY) 2025–26 Proposed State Budget. Reflecting a modest revenue surplus of $16.5 billion, yet also $7.1 billion in reserve withdrawals, the $322.3 billion total budget would generally maintain this year's current budget without major spending reductions or new commitments. Medi-Cal eligibility would remain unchanged, including coverage for all individuals regardless of immigration status. No major modifications to Medi-Cal services are proposed — with the exception of the new Transitional Rent benefit approved in December 2024 by the U.S. Centers for Medicare & Medicaid Services (CMS). In addition, due to Proposition 35's passage in November 2024, new Medi-Cal rate increases derived from the Managed Care Organization (MCO) Tax are anticipated in calendar year 2025 once a spending plan is developed by the California Department of Health Care Services (DHCS) in consultation with a stakeholder advisory committee. However, current risk factors that could negatively impact the state's economy and revenues include policy changes by the federal government, stock market volatility and geopolitical uncertainty. Overall state budget shortfalls are also anticipated in subsequent FYs as expenditures outpace revenues. For further details and potential impacts, a CalOptima Health-specific analysis follows my report in the Board materials. Next, the State Legislature will conduct hearings to review the proposed budget, and the governor will then release a revised proposal (May Revision) by May 14.

Government Affairs Advocacy Updates

- **Federal:** Over the past several weeks, CalOptima Health leadership has engaged extensively with federal lawmakers to share our concerns regarding budget reconciliation proposals in Congress that could reduce Medicaid funding and/or restrict eligibility. In collaboration with our federal associations and lobbyists, Government Affairs leaders traveled to Washington, D.C., to meet with legislative aides for all members of Orange County's federal delegation, including U.S. Sens. Alex Padilla (D) and Adam Schiff (D) and U.S. Reps. Linda Sanchez (D), Young Kim (R), Derek Tran (D), Lou Correa (D), Dave Min (D) and Mike Levin (D). Staff also met with aides for other members of Congress who hold important leadership roles or sit on committees impacting health care programs, including Senate Health, Education, Labor and Pensions Committee Chairman Bill Cassidy (R-LA), House Democratic Caucus Chairman Pete Aguilar (D-CA), House Budget

Committee Chairman Jodey Arrington (R-TX), and U.S. Reps. Jay Obernolte (R-CA) and Nanette Diaz Barragán (D-CA), who are members of the House Energy and Commerce Committee's Health Subcommittee. In addition, CalOptima Health executives met directly with Reps. Kim and Tran here in Orange County. Staff is closely monitoring ongoing developments in Congress and will continue to advocate on behalf of our members, providers and stakeholders.

- **State:** February 21 was the deadline for California legislators to introduce new legislation for the 2025 calendar year. Despite this session's reduced limit of 35 bills per legislator (down from 50 in the Assembly and 40 in the Senate last year), several significant health care bills were introduced before the deadline. In collaboration with our state associations and lobbyists, staff will be analyzing bills in the coming weeks to determine potential impacts to CalOptima Health and our members, providers and stakeholders. Staff will then engage with impacted departments regarding any significant legislation to inform potential advocacy efforts as bills are considered by committees and advance through the legislative process this year.

B. DHCS Requests PACE Sanction Authority in Proposed Trailer Bill

As part of the FY 2025–26 state budget process, DHCS has proposed "trailer bill language" that would grant the regulator authority to impose sanctions on Program of All-Inclusive Care for the Elderly (PACE) organizations for noncompliance. These could include monetary sanctions ranging from $15,000 to $100,000 per infraction, enrollment and marketing restrictions, subcontractor terminations, service suspensions, and temporary management oversight. Monetary penalties may apply for issues such as failure to provide medically necessary services, misrepresentation of information, discriminatory practices, network adequacy failures and delays in required reporting. DHCS may also withhold payments, require corrective action plans and hold public hearings before imposing certain sanctions. At the same time, DHCS is also requesting an increased budget to hire 33 permanent positions to support PACE growth across the state and to ensure that current PACE organizations are sustained. This increased funding would be sourced from new fees on PACE organizations, including application/expansion fees, annual maintenance fees based on enrollment, and marketing fees for mass mailer participation, as well as matching federal funds. While additional DHCS support for PACE is welcome news, the California PACE Association will engage DHCS to discuss concerns about these proposals. I will share further updates as the state budget process continues over the coming months.

C. ECM Academy: Cohort 3 Vetting Process and Selections Announced

CalOptima Health has a unique model for working with and training community-based organizations that provide health care services, mental health services, homelessness and housing services and other community services through an Enhanced Care Management (ECM) Academy. Through an application and vetting process, selected organizations participate in CalOptima Health's six-month training and onboarding program and are subsequently credentialed and contracted as ECM providers. The third cohort has recently been selected and will be comprised of 12 organizations. CBOs serving children and youth populations were encouraged to apply, and CalOptima Health received a total of 101 applications. The vetting process included an assessment of each organization's ability to meet capacity requirements (serving 60 members by year one), research on their mission and experience and in-person interviews. Cohort three includes the following CBOs and the ECM Academy will begin in April with contracted services slated to begin on October 1:

- Boys & Girls Club Garden Grove
- Council on Aging Southern California
- Dr. Patricia's Health Club, Inc.
- Heritage Health Network
- Human Options

- Koinonia Foster Homes
- Meals on Wheels
- Mercy Pharmacy
- Nurturing Care
- OCAPICA
- Pair Team
- Vynca

D. Two New WellSpaces Open to Support Better Mental Health for Students

CalOptima Health celebrated the grand opening of two new WellSpaces at Marina High School in Huntington Beach and Loara High School in Anaheim. These WellSpaces are among the 10 funded by CalOptima Health's Student Behavioral Health Incentive Program (SBHIP), which invested $25.5 million in a variety of mental health interventions in all 29 Orange County school districts. CalOptima Health collaborates with CHOC/Rady Children's Health and the Orange County Department of Education on each WellSpace, which is a location on campus that provides students with a safe space to practice social-emotional learning skills and de-escalate mental health concerns. The WellSpaces are intended to help students develop resilience, perseverance and adaptability. The grand opening of the Loara WellSpace was covered by NBC4.

E. Video Series Features CalOptima Health Member's Story of Becoming Housed

CalOptima Health's newest member video tells the inspiring story of Maggie Noble's journey from experiencing homelessness to her joy at receiving housing at Santa Angelina, an affordable senior housing community in Placentia. Through the Housing and Homelessness Incentive Program (HHIP), CalOptima Health granted $1.3 million to National CORE for the development of Santa Angelina's 65 affordable apartment homes for seniors. Twenty-one units are set aside as permanent supportive housing for unhoused seniors or seniors at risk of becoming unhoused.

F. DHCS Releases Final Community Reinvestment Guidance

DHCS has released the final All Plan Letter (APL) 25-004: Community Reinvestment Requirements, which provides guidance to Medi-Cal managed care plans about reinvesting a minimum level of their net income in their local communities. In response to plans' concerns with the draft APL released in September 2024, DHCS is no longer requiring a shared governance process for developing reinvestment plans and has also added grandfathering provisions to allow current community investments to be claimed in 2024 reinvestment obligations. While DHCS did not accept many of the other requested changes, the California Association of Health Plans will continue to advocate as implementation begins.

G. Guide to Immigration Resources Developed

CalOptima Health developed a two-page list of immigration resources in collaboration with the Orange County Health Care Agency and the County of Orange Social Services Agency. It was distributed to all staff if conversations with members and providers lead to this topic and the need to share helpful resources in the current climate. View the document online.

H. CalOptima Health Gains Media Coverage

- On February 3, CalMatters published an article titled "California voters erased a plan to keep kids insured. It might be too late to fix it." I was quoted about the importance of continuous coverage starting in childhood and what it means to the health trajectory of our most vulnerable members. Since the article was first published, it has been widely syndicated.

- On February 8, Chief Operating Officer Yunkyung Kim was interviewed by the Orange County Register about the Board of Directors' action to rescind the letter of support for 360 PACE.
- On February 10, BeckersPayer.com published an article after interviewing me about CalOptima Health's plans to join Covered California. The conversation also resulted in a related podcast.

CalOptima Health

Fast Facts
March 2025

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

Membership Data* (as of January 31, 2025)

Total CalOptima Health Membership

915,151

Program	Members
Medi-Cal	897,559
OneCare (HMO D-SNP)	17,090
Program of All-Inclusive Care for the Elderly (PACE)	502

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

Key Financial Indicators (for seven months ended January 31, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$48M	$228.9M	126.5%
Non-Operating Income/(Loss)	●	$102.3M	$64.6M	171.5%
Bottom Line (Change in Net Assets)	●	$150.3M	$293.5M	205.0%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	93.2%		-7.2%
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.1%		1.7%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 88.8%.

Reserve Summary (as of January 31, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,091.6
Statutory Designated Reserves	$136.3
Capital Assets (Net of depreciation)	$101.5
Resources Committed by the Board	$451.9
Board Approved Provider Rate Increase**	$403.4
Resources Unallocated/Unassigned*	$410.7
Total Net Assets	$2,595.4

* Total of Board-designated reserves and unallocated resources can support approximately 142 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4 Billion**

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

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CalOptima Health Fast Facts

March 2025

Personnel Summary (as of February 2, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,334.75	48.65	56.82%	43.18%	3.52%
Supervisor	82	3	100%	--	3.53%
Manager	119	4	25%	75%	3.25%
Director	69	5	40%	60%	6.76%
Executive	21	0	--	--	--
Total FTE Count	1,625.8	61.7	47.89%	52.11%	3.65%

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

Provider Network Data (as of February 23, 2025)

	Number of Providers
Primary Care Providers	1,318
Specialists	7,054
Pharmacies	601
Acute and Rehab Hospitals	43
Community Health Centers	65
Long-Term Care Facilities	206

Treatment Authorizations (as of December 31, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	43.20 hours
Prior Authorization – Urgent	72 hours	13.26 hours
Prior Authorization – Routine	5 days	1.73 days

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

Member Demographics (as of January 31, 2025)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	35%
45 to 64	20%
65 +	14%

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

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	37%
Expansion	38%
Seniors	11%
Optional Targeted Low-Income Children	8%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Fiscal Year 2025–26 Proposed State Budget

Background
On January 10, Governor Gavin Newsom released his FY 2025–26 Proposed State Budget. Subsequently, the California Department of Health Care Services (DHCS) released its budget highlights and Medi-Cal estimate. The budget proposal reflects a point-in-time assessment of California's finances and administrative priorities, with adjustments expected in a Revised Budget Proposal (May Revision) to be released on or before May 14.

Summary
Overall, Gov. Newsom's proposal reflects an upcoming budget that will — for the most part — maintain the status quo without major spending reductions or new commitments.

The FY 2025–26 Proposed State Budget includes $322.3 billion in total funding ($228.9 billion General Fund [GF]) and anticipates a modest revenue surplus of $16.5 billion compared to FY 2024–25. The governor presented a balanced budget with $17 billion in reserves — after withdrawing $7.1 billion from those reserves as part of the two-year balancing plan included in the current FY 2024–25 Enacted State Budget to address last year's deficit.

Looking forward, Gov. Newsom highlighted several risks that may negatively impact expected state revenue, including policy changes by the incoming federal administration, stock market volatility, increased inflation and geopolitical uncertainty. Budget shortfalls are also anticipated in subsequent FYs as expenditures outpace revenues, despite the significant reserves proposed for FY 2025–26.

Medi-Cal Overview
Medi-Cal enrollment in the current FY 2024–25 has been higher than projected in the Enacted State Budget, resulting in an estimated $3 billion ($1.1 billion GF) cost increase. However, caseloads are expected to remain relatively stable or slightly decline through the remainder of the FY while unwinding flexibilities remain in place until June 30, 2025. Once these flexibilities are eliminated, a steeper caseload decline is projected in the upcoming FY 2025–26. Specifically, projected Medi-Cal enrollment for FY 2025–26 is 14.5 million per month, a decrease of 3.09 percent from FY 2024–25.

Despite anticipated caseload reductions, the overall Medi-Cal budget is estimated to increase year-over-year to $188.1 billion total ($42.1 billion GF) in FY 2025–26 due to increased program costs. While there are no proposed changes to Medi-Cal eligibility, including the previously enacted expansion for individuals with unsatisfactory immigration status, the budget estimates an FY 2024–25 increase of $2.7 billion for this population due to higher than anticipated enrollment and increased pharmacy costs. Overall Medi-Cal pharmacy expenditures are expected to increase $1.6 billion ($1.3 billion GF) in the current FY 2024–25 and another $1.2 billion ($215.2 million GF) in the upcoming FY 2025–26 due to increased utilization of high-cost drugs, including anti-obesity medications.

California Advancing and Innovating Medi-Cal (CalAIM)
Gov. Newsom's proposed budget estimates $1.2 billion in expenditures for CalAIM Enhanced Care Management (ECM) and Community Supports, a reduction of $491.1 million from FY 2024–25 driven by the completion of plan incentive payments. However, these expirations are partially offset by an increase in ECM expenditures and the addition of Transitional Rent costs sometime in 2025 (*see later*).

Proposition 35 — Managed Care Organization (MCO) Tax

Approved by voters in November 2024, Proposition 35 permanently reauthorized the MCO Tax that was enacted in 2023 and originally set to expire at the end of 2026. The latest amendments to the MCO Tax were approved by the U.S. Centers for Medicare & Medicaid Services (CMS) on December 20, 2024.

In addition, Proposition 35 outlined permissible uses of the MCO Tax revenues to increase funding for the Medi-Cal program, starting in 2025. DHCS must next consult with a stakeholder advisory committee to develop and implement a specific spending plan. The targeted rate increases for primary care, maternal care and non-specialty mental health services that were previously effective on January 1, 2024, will be maintained, but future investments that were authorized in the FY 2024–25 Enacted State Budget are now inoperable in order to accommodate the new expenditures approved by Proposition 35.

Due to the proposition's restriction on the use of MCO Tax revenues to cover existing state costs, the proposed budget reflects a $2.2 billion decrease in available revenue from FY 2024–25 to FY 2025–26.

Senate Bill (SB) 525 Health Care Minimum Wage Impacts

On October 16, 2024, the health care minimum wage increase went into effect after DHCS notified the Joint Legislative Budget Committee that it had initiated the data retrieval process necessary to increase the Hospital Quality Assurance Fee (HQAF) beginning January 1, 2025. Also on December 11, 2024, DHCS submitted a request to CMS to significantly increase the Private Hospital Directed Payment (PHDP) by roughly $6 billion total, beginning January 1, 2025, for services rendered in 2025. The large increases to the HQAF and PHDP partially mitigate cost pressures on managed care plans resulting from the minimum wage increases, as hospitals will have significant new revenue available. As such, Mercer significantly discounted the impact of SB 525 on 2025 plan rates.

Behavioral Health

In December 2024, DHCS received CMS approval of $8 billion in total funding to implement the five-year BH-CONNECT demonstration, effective January 1, 2025, through December 31, 2029. The proposed budget allocates a total of $29.5 million ($655,000 GF) for FY 2024–25 and $784.3 million ($31.6 million GF) for FY 2025–26. While most of the demonstration will be implemented through the county behavioral health delivery system, BH-CONNECT does include the new Transitional Rent benefit to be offered by MCPs to eligible high-need members for up to six months. Another component of the demonstration includes the $1.9 billion statewide Behavioral Health Workforce Initiative to be administered by the California Department of Health Care Access and Innovation (HCAI).

Gov. Newsom's budget proposal also includes an additional $93.5 million ($55 million GF) in FY 2025–26 for counties to administer the Behavioral Health Services Act (BHSA) recently approved by voters in March 2024 as part of Proposition 1 and Behavioral Health Transformation (BHT).

Miscellaneous

Other provisions in the governor's proposed budget include:

- Establishment of a new California Housing and Homelessness Agency to create a more integrated and effective administrative framework for addressing housing and homelessness issues. More details will be released this spring as part of a reorganization plan.
- A new investment of $7.4 million GF in FY 2025–26 to provide a three-month supply of free diapers for families with newborns, to be administered by HCAI through hospitals systems.

Next Steps

In the coming months, the State Legislature will hold committee hearings to review the governor's proposed budget as well as consider its own counterproposals. Gov. Newsom will then release his May Revision by May 14, which incorporates updated revenue projections. Finally, the governor and State Legislature must negotiate and enact a final budget by July 1.

Staff will continue to monitor budget developments as well as the release of forthcoming Trailer Bill Language, which reflects specific policy changes that would be needed to implement certain proposed budget expenditures. Further updates will be shared regarding any budget proposals that may impact CalOptima Health. Staff will also work closely with legislators and stakeholders to advance CalOptima Health's priorities throughout the budget process.

If you have any questions, please contact Government Affairs at GA@caloptima.org.

Enhanced Care Management (ECM) Academy: Cohort 3 Vetting Process & Selections

Board of Directors Meeting
March 6, 2025

Kelly Bruno-Nelson, Executive Director, Medi-Cal& CalAIM

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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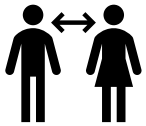
CalOptima Health's ECM Model

Community-Based: Engage a diverse pool of providers that have experience & expertise serving DHCS populations of focus.

Support Driven: Give providers the training and education they need to deliver trauma informed, person-centered ECM services. Providers receive on-going support in working with CalOptima Health.



In-Person Focused: Ensure wide-coverage across the County for in-person services to ensure relationships are built with members. Emphasis on contracting with providers that have brick and mortar sites in Orange County.

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CalOptima Health

ECM Academy: Program Overview

- The ECM Academy is a 6-month training and onboarding program for organizations selected to be contracted as ECM providers.
  - Concurrent to participating in the Academy, organizations are credentialed and contracted as ECM providers.

- Two ECM Academy cohorts were completed in 2023-2024, graduating 50 ECM providers consisting of:
  - 52% Community Based Organizations
  - 24% Community Health Centers
  - 14% Health Networks
  - 10% Other (Street Medicine Provider, CBAS, etc.)

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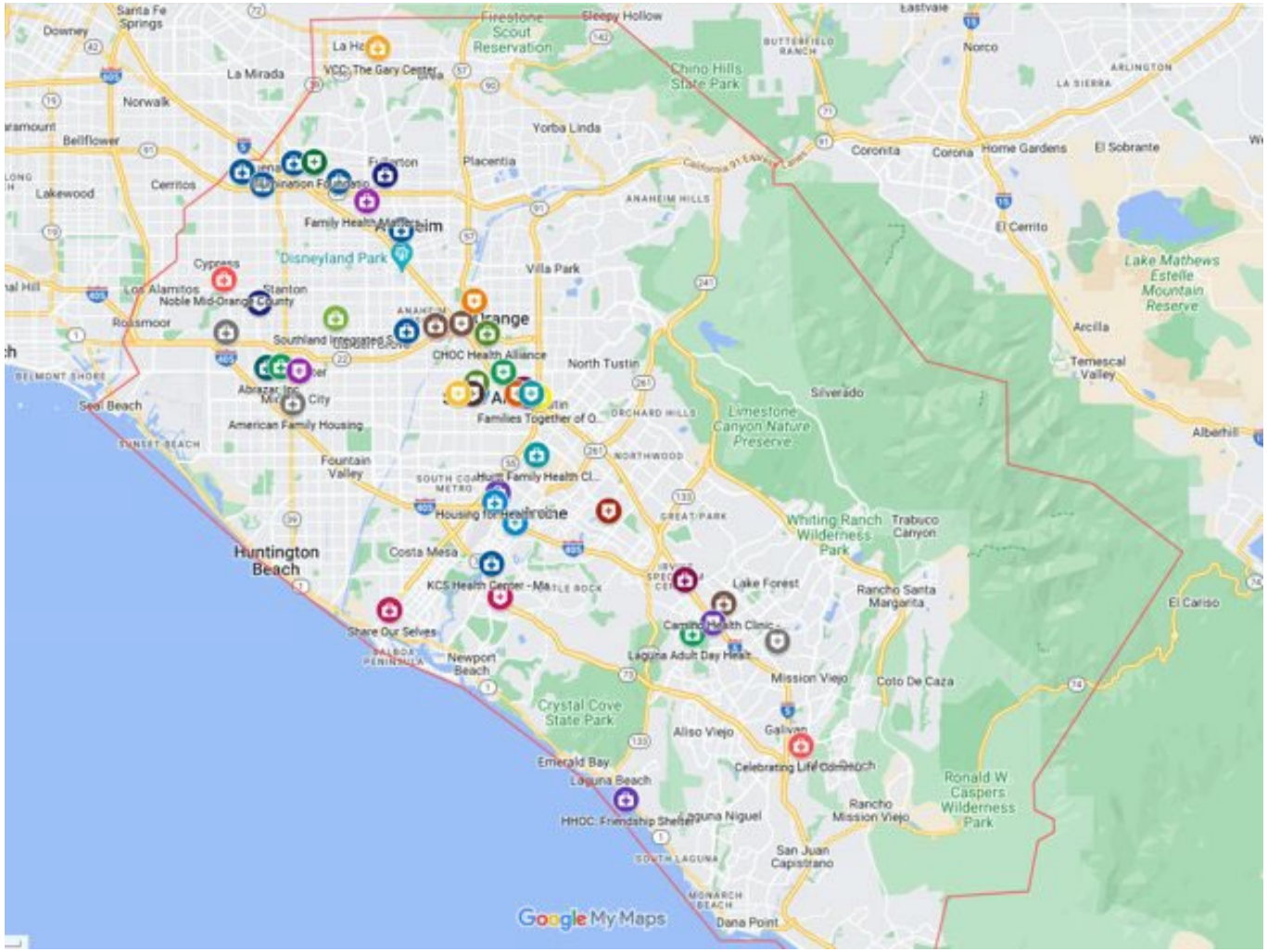
CalOptima Health

ECM Current Coverage Map



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ECM Academy: Cohort 3 Application Process

- The application portal for the third ECM Academy Cohort was open from 5/9/24 – 10/3/24.
- Organizations that serve children and youth populations were encouraged to apply.
- 101 applications were received.

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CalOptima Health

ECM Academy: Cohort 3 Vetting Process

- The vetting process to review applicants including a scoring process reflective of the following elements:

1. Review of ECM application & application supplement.
2. Research on the mission, experience and expertise of the applicant organization.
3. Assessment of each organization's ability to meet capacity requirements (serving a minimum of 30 members by 6 months and 60 members by one year).
4. In-person interviews with key applicant staff.

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CalOptima Health

ECM Academy: Cohort 3 Selections

1. Vynca
2. OCAPICA
3. Heritage Health Network
4. Boys & Girls Club Garden Grove
5. Council on Aging Southern California
6. Koinonia Foster Homes
7. Nurturing Care
8. Human Options
9. Meals on Wheels
10. Mercy Pharmacy
11. Dr. Patricia's Health Club, Inc.
12. Pair Team

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CalOptima Health

Next Steps

- All providers will be notified of their application status in March.
- The ECM Academy will begin in April.
- Participating organizations will graduate from the Academy and be contracted to start ECM services October 1st.

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Covered California Progress Update

Board of Directors Meeting
March 6, 2025

Donna Laverdiere
Executive Director, Strategic Development

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Agenda

- Covered California Background
- Previous Board Actions Review
- Progress Updates
- Q&A/Discussion

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Covered CA Background

Covered CA Overview

- Covered California (Covered CA) is the California state-based Marketplace program through which eligible Californians can purchase individual insurance coverage for themselves and their families
- California residents who are not eligible for Medi-Cal or employer-sponsored insurance can purchase a plan through Covered CA
- Premium subsidies are available to qualifying individuals and families
- The type of plans offered in Covered CA are called Qualified Health Plans (QHPs)
- CalOptima Health would be seeking to join the Covered CA market for the 2027 plan year
- Covered CA advises that new plans need a two-year runway to prepare for participation

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Essential Health Benefits

QHPs are required to offer a set of 10 Essential Health Benefits. The state selects a benchmark plan that sets forth the benefit standards that all QHPs must follow.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

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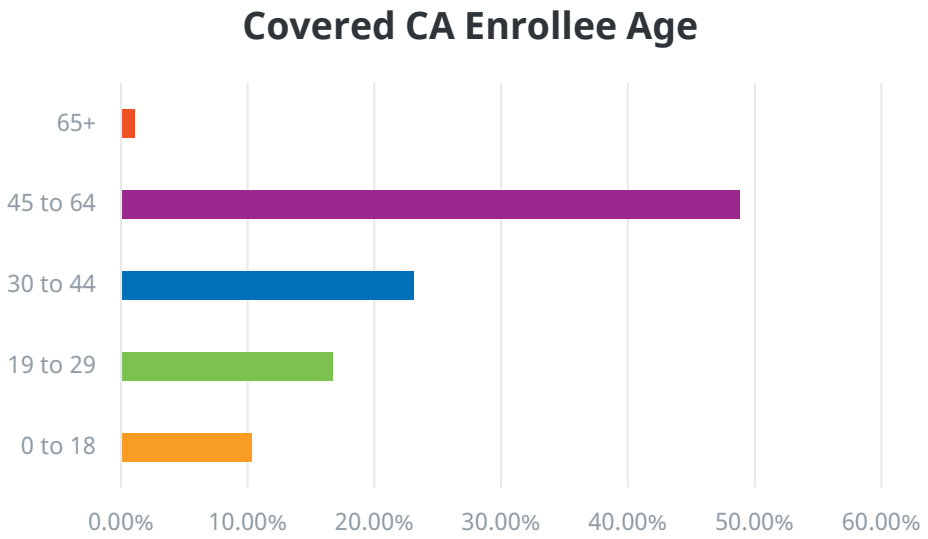
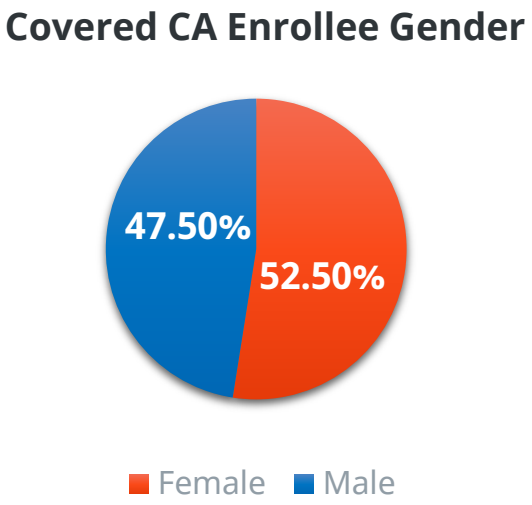
CalOptima Health

Covered CA Orange County Enrollment Data

- Total Orange County enrollment, as of February 1, 2025: **185,760**





Enrollment Breakdowns Source: LHPC Databook for Coverage Month April 2024

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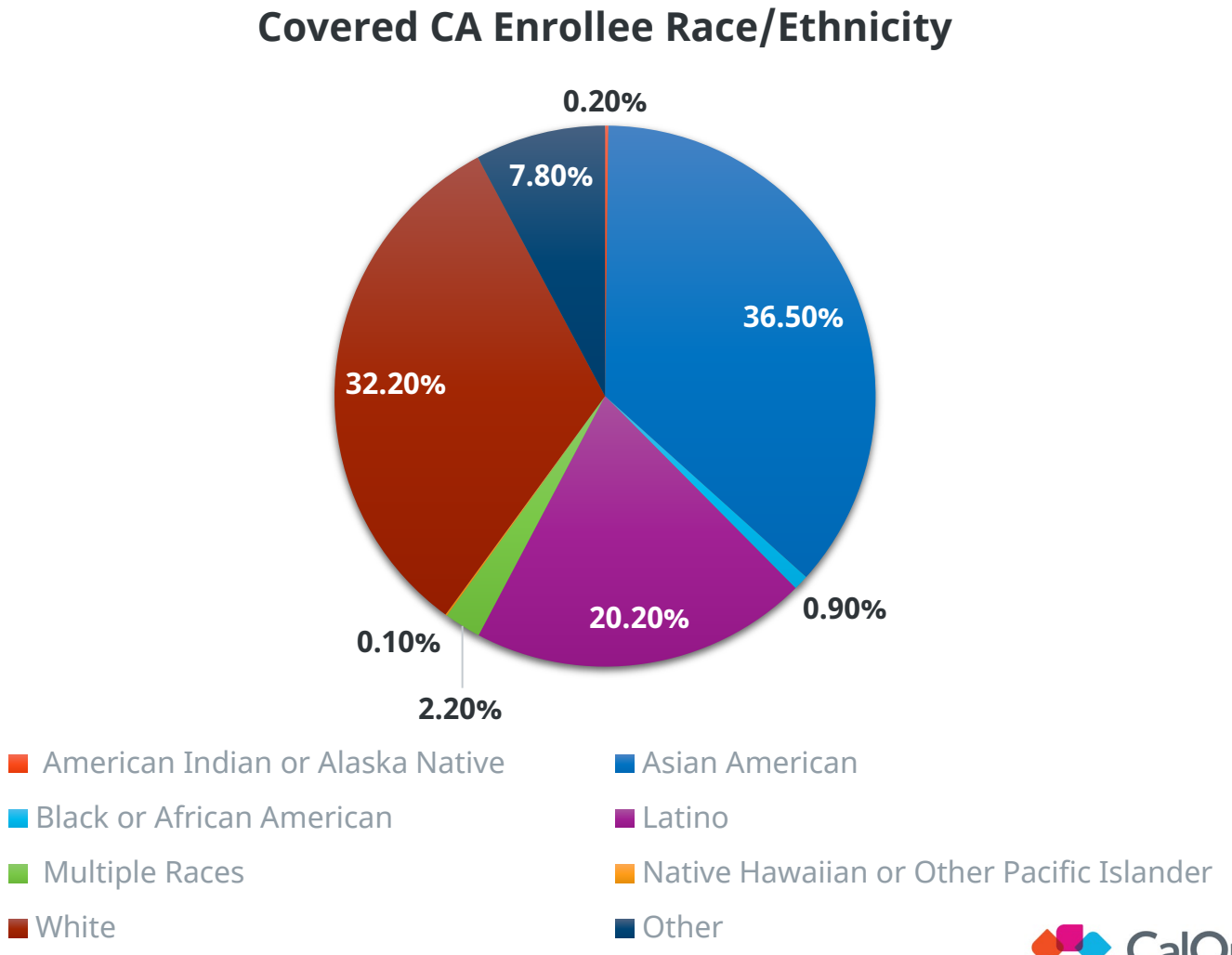
Covered CA Orange County Enrollment Data (cont.)



Enrollment Breakdowns Source: LHPC Databook for Coverage Month April 2024

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Review of Previous Board Actions

Previous Board Action — August 2024
Stakeholder Engagement

- On **August 1, 2024**, CalOptima Health's Board of Directors approved the convening of a Steering Committee comprised of 12 external stakeholders to inform the design and development of CalOptima Health's potential Covered CA line of business.
- The Stakeholder Steering Committee has met seven times since August 2024.

Stakeholder Steering Committee Membership:

- Hospital Association of Southern California (HASC) Rep. — **Sara May**
- Orange County Medical Association (OCMA) Rep. — **Connie Bartlett, D.O.**
- Safety Net Hospital Rep. — **Randolph P. Siwabessy,** UCI Health
- Pediatric Hospital Rep. — **Jena Jensen,** Children's Hospital of Orange County
- Large Health Network Rep. — **Ray Chicoine,** Optum Orange County
- Small Health Network Rep. — **Toan Q. Tran, M.D.**, Family Choice Health Services
- Coalition of Orange County Community Health Centers — **Sonia Shah**
- Community Clinic Rep. — **Jenny Q. Nguyen,** Nhan Hoa Comprehensive Health Care Clinic
- Member Advisory Committee Chair — **Christine C. Tolbert**
- Provider Advisory Committee Chair — **John H. Nishimoto, O.D.**
- Office of O.C. Supervisor Vicente Sarmiento — **Vasila Ahmad**
- Office of O.C. Supervisor Doug Chaffee — **Al Jabbar**

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Previous Board Action — October 2024
Guiding Principles and Ordinance Change

- On **October 3**, **2024**, the CalOptima Health Board of Directors approved seven Guiding Principles for Covered CA participation and authorized the CEO to seek a change to the governing ordinance to allow participation in Covered CA
- The ordinance change was approved by the O.C. Board of Supervisors on January 14, 2025

Guiding Principles

1. Through Covered CA participation, provide continuous, high-quality care to our members across changes in life circumstances.
2. Ensure sufficient provider reimbursement in alignment with the current Covered CA market in Orange County.
3. Consistently engage external stakeholders on an ongoing basis to inform the design, development and implementation of the program in a transparent way.
4. Be strong stewards of public funds by identifying opportunities for efficiency and careful investment in needed capabilities.
5. Ensure ongoing reinvestment in the Orange County community as a key tenet of Covered CA participation.
6. Start small and target individuals and families churning on and off Medi-Cal coverage.
7. Ensure network adequacy standards are aligned with access and availability to care for our members.

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Previous Board Action — December 2024
Consulting Support Budget Approval

- On **December 5, 2024**, the CalOptima Health Board of Directors approved three (3) consultant support actions that enabled CalOptima Health to progress with the pre-work necessary to prepare for entrance into Covered CA
  - Combined $4.75 million over the start-up period (out of total estimated $16 million start-up budget)

Contract	Description	Approved Budget
Strategic Advice and Qualified Health Plan Application Support	Contract amendment with HMA for comprehensive and strategic guidance on business strategy, regulatory requirements and the QHP Application	$250,000 ***Completed***
Actuarial Support for Financial Projections and Rate Development	Direct contract with Milliman for rate setting and pro forma/pricing sensitivity, risk adjustment and enrollment projections	$1,500,000 ***Completed***
Operational Implementation Support and Project Management	Release RFP for consultant support for operational gap assessment, core operations and IT system implementation	$3,000,000 ***RFP responses received on March 3***

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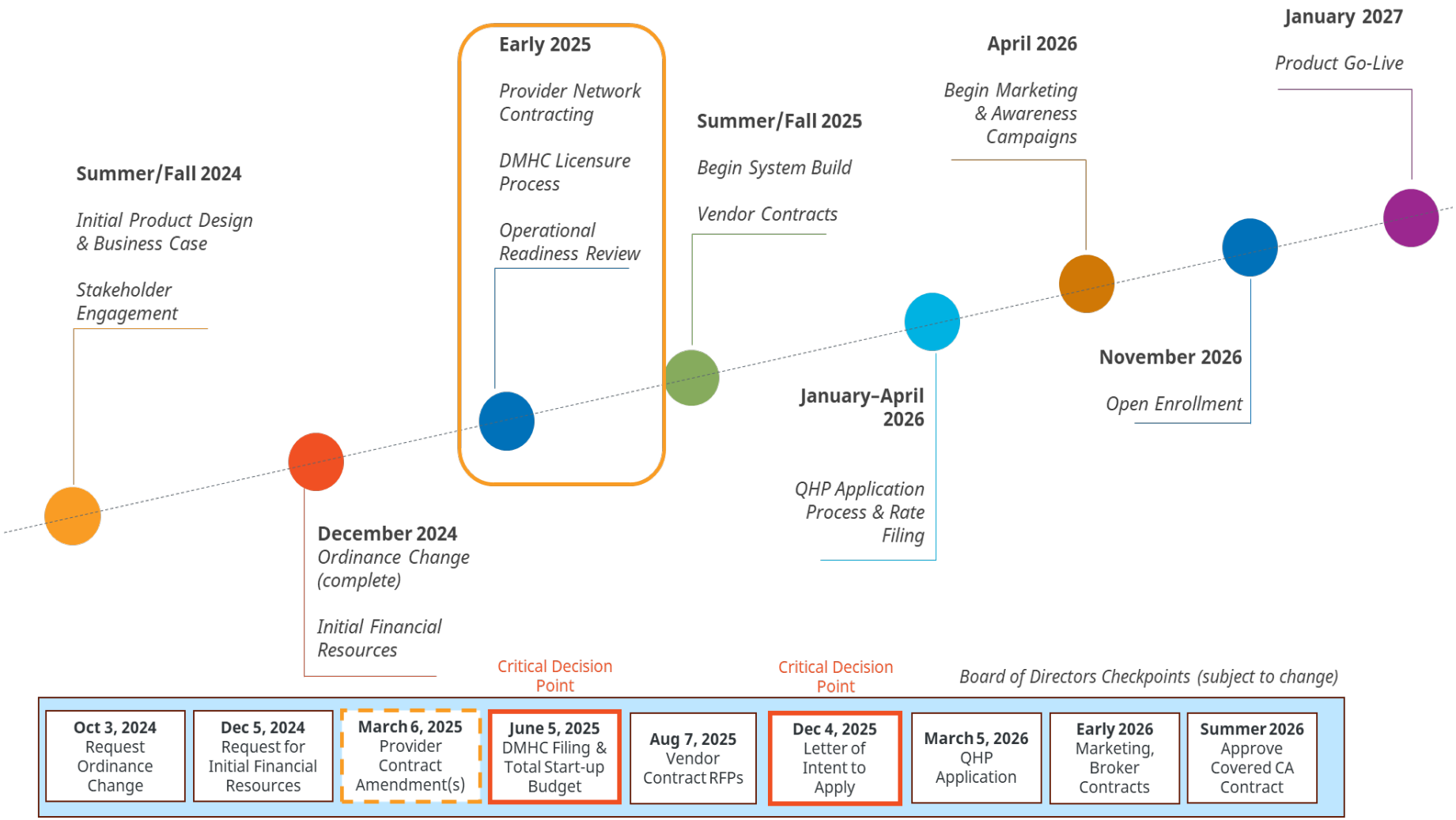
Progress Updates

Covered CA Implementation Timeline



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Provider Network Contracting Update

- Provider network design and development is underway
- Updated provider contract templates are being presented at today's Board meeting for consideration
- Following contract template approval, the Provider Network team will begin working to contract the provider network required for DMHC licensure approval

Network Development Guiding Principles

1. Preserve and promote continuity of care
2. Comply with access requirements
3. Comply with, and promote, quality requirements
4. Build on our current delegated delivery model and current contracted providers
5. Ensure adequate volume to benefit contracted providers
6. Expand the network as the membership grows
7. Engagement/collaboration on building the network

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CalOptima Health

DMHC Licensure Update

- CalOptima Health must obtain a Knox-Keene Act license from the California Department of Managed Health Care (DMHC). This filing process begins in **June 2025**.
  - ✓ Pre-filing conference was held on 2/25/2025
- DMHC requires the filing of numerous exhibits detailing the organization, policies and procedures that demonstrate compliance with Knox-Keene Act requirements, network data, and other materials
- Staff will return to the Board for approval of the submission of the initial filing package

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Operational Readiness Update

- √ Strategic and actuarial support contracts are in place
- √ RFP responses to the Operational Implementation Support contract were received on March 3, 2025
  - Staff aims to bring the recommended vendor to the Board for approval on April 3, 2025
  - IT and staffing resource planning are underway
  - Staff are developing a staffing plan and a full implementation budget for the Board's consideration on June 5, 2025

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Upcoming Board Actions
Subject to Change

Board Meeting	Item
March 5, 2025	• Provider Contract Templates
April 3, 2025	• Operational Implementation Support vendor selection
May 1, 2025	• Covered CA Policies & Procedures
June 5, 2025	• Initial DMHC Licensure Filing • Full Implementation Budget

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Q&A/Discussion

CalOptima Health

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Board of Directors Meeting
March 6, 2025

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on February 13, 2025.

The MAC welcomed their two new OneCare Members or Authorized Family Members. Peter Hersh, who represents his father who is a OneCare member and Paul Kaiser also a OneCare Member. Both new members were appointed by the CalOptima Health Board of Directors at its February 6, 2025 meeting.

Val Brauks, Executive Director,Children and Families Coalition of Orange County (CFCOC), presented on Every Family Home Visiting Collaborative which is led by Vital Access Care Foundation (VACF). VACF improves the health and well-being of underserved communities, particularly focusing on Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations. She noted that through education, advocacy, and comprehensive healthcare services, VACF strives to reduce health disparities and provide culturally competent care that meets the unique needs of these communities. VACF is a lead organization of the API Task Force, a collaborative of 20 direct service community-based organizations focused on social services and healthcare for Orange County's AA and NHPI communities. VACF will be working with the YMCA of Orange County who will be serving as the administrative, fiscal lead and will provide direct service via a home visitor and is supported by the CFCOC. This collaboration includes partnerships that will expand home visiting services for racial and ethnic populations, as well as children with disabilities in addition to the CalWORKs population and other infant and toddler home visiting programs. Ms. Brauks also reviewed the Children and Youth Behavioral Health Initiative (CYBHI) that was adopted in 2021 which seeks to reimagine the systems, regardless of payer, that support behavioral health for al California's children, youth, and their families.

Veronica Carpenter, Chief Administrative Officer, presented an update on the Covered California Initiative noting that the five Orange County Board of Supervisors unanimously approved the change to CalOptima Health's Ordinance. She thanked the MAC and PAC for their feedback and engagement and support and looks forward to continuing to work with the committees on this effort noting that CalOptima Health's guiding principles would remain the same. Ms. Carpenter noted that the CalOptima Health website had been updated to include a page dedicated to Covered California and added that the CalOptima Health Board has allocated $5 million cumulatively for startup contracts. She noted that CalOptima Health has fully started planning and implementation so that it is ready to go live in January 2027. She also discussed how the contracts include an actuarial support for financial protections and rate development with Milliman for $1.5 million along with Health Management Associates for

approximately $250,000. Another $3 million would be used for a Request for Proposal (RFP) for operational support services. She also noted that CalOptima Health had kicked off all of the major work streams internally to meet this very aggressive timeline which includes the Department of Managed Health Care licensing process and that they would be providing in-depth analysis of what the Covered California network would like and that she planned to bring this item back to the committees before it goes to the Board in June. Ms. Carpenter answered several questions from the committee about the Milliman rate development and noted that they had assisted the Inland Empire Health Plan with their rate development and that Milliman is an actuarial firm that is familiar with CalOptima Health.

Michael Gomez, Executive Director, Network Operations, presented on the Prospective Health Network Policy and Procedure. Mr. Gomez discussed how CalOptima Health had received several inquiries from entities asking if it was open to add a new health network and after a review of CalOptima Health policies it was determined that there was a need to create a new policy. To assist with this effort CalOptima Health reached out for input from its health networks, Federally Qualified Health Centers (FQHCs), and the MAC and PAC, and has created a tracking log of various responses and comments. This tracking log was reviewed with CalOptima Health directors for input on the suggestions that were received. Mr. Gomez also reviewed the process for approval and noted that it is the intent of Network Operations to present and ask for policy approval at the March 6, 2025 Board meeting. He also reviewed next steps with the committees once the policy was approved. Several committee members expressed their appreciation for being kept apprised of this new policy and how it has been an inclusive process not only with the networks and FQHCs but with the MAC and PAC as well.

Yunkyung Kim, Chief Operating Officer, highlighted a few items of interest to the committees noting that the 2025 Report to the Community had been released and it is available on the CalOptima Health website and that hard copies were in the mail. She noted that it highlights what a great year CalOptima Health had in 2024 and that if there was a theme to the 2025 Report to the Community it was about partnerships that were established through the entire Orange County community. Ms. Kim also provided an update on enrollment numbers and noted that December numbers increased by 8,000 new members but noted that it is a constantly fluctuating number with end of year showing an increase and then again mid-year and that CalOptima Health was keeping a close eye on how membership trends in 2025. Ms. Kim also provided an update on how the Board approved for CalOptima Health management to continue negotiating with Providence Health in an effort to bring them on as a health network.

Richard Pitts, D.O., Ph.D, Chief Medical Officer, presented information on Silicosis, an incurable lung disease that can lead to disability and death. He noted that Silica dust can also cause lung cancer, chronic obstructive pulmonary disease, kidney disease and autoimmune disease and that individuals with a history of working in cutting and finishing countertops are at risk for silicosis. Dr. Pitts also discussed how providers should educate and ask their patients about their work and suspect silicosis in countertop fabrication workers and that providers should report identified cases to the California Department of Public Health.

Veronica Carpenter provided an update to the committees on how CalOptima partnered with five Asian American Pacific Islander organizations, including Korean Community Services, Orange County, Asian Pacific Islander Community Alliance, the Cambodian Family, Southland Integrated Services and the Vietnamese American Cancer Foundation to highlight the $3 million grant that CalOptima Health awarded these organizations as part of the cancer prevention program which received some media attention from Vietnamese TV and then also ran in the Times OC. She noted that CalOptima Health was

also partnering with KTLA on a program called Unscripted, which is being filmed in February to focus on CalOptima Health's senior programs, PACE and OneCare. The Unscripted programs should start to air sometime in early March. On the Medi-Cal expansion front, Ms. Carpenter noted that CalOptima Health had received 12 community partners who were funded for community enrollers to assist with Medi-Cal renewals and that they would help with Cal Fresh enrollment as well. CalOptima Health will host an event on Saturday March 1, in partnership with the City of Laguna Niguel and allow CalOptima Health to put a footprint into a new community down in South County.

She also noted that the Board had approved the 2025 2027 strategic plan and thanked the committees for their feedback and helping draft the strategic plan. She noted that on the Government Affairs side that Robert F Kennedy, Jr ., had been confirmed as the Health and Human Services Secretary on a 52 to 48 vote.

Ms. Carpenter asked the members of the committees to please share any member stories on how important Medicaid funding is for CalOptima Health members, and the need ensure its sustainability to keep the current members that it serves healthy. Members of the committee asked several questions and noted that there was a lot of fear in the county especially for FQHC's with Immigration Control Enforcement (ICE) out in the communities.

Committee members thanked Ms. Carpenter for the in-depth legislative report as this is something that was done in the past and they were glad to see it return as a regular report item.

Michael Hunn, Chief Executive Officer, assured the committees that CalOptima Health would not disclose any personal information, protected health information of any member for any reason. No data would be shared. He noted that the FQHCs had been impacted with a significant drop in visits some as high as 25% of the community clinics and that the FQHCs could not survive with a 25% reduction in revenues to keep their operations and doors open and that over 400,000 plus CalOptima Health members find their medical home in the community clinics and that the community clinics account for 1.2 million visits a year. He also noted that CalOptima Health was looking at strategic approaches to assisting the clinics. Mr. Hunn also discussed the Governor's budget and noted that continuous eligibility for children 0-5 will end in January 2026, which would then require families to go through another application process with the Social Services Agency to maintain their coverage. He noted that there were about 75,000 individual children that fall into the 0-5 category.

Mr. Hunn also discussed how the collaboration and communication that exists between the members of the MAC and PAC and CalOptima Health is critical as the committees are the eyes and ears of the CalOptima Health members and he asked the members to keep staff apprised of anything they hear out in the community.

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

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

February 6, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on February 6, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person; at the teleconference location: Morrison Clark Historic Inn & Restaurant, 1011 L St. NW, Check in at the front desk for exact location, Washington, DC 20001, which was accessible by members of the public; and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Vice Chair Vicente Sarmiento called the meeting to order at 2:02 p.m., and Director Catherine Green, R.N., led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting)

(All Board members participated in person, except Isabel Becerra, Chair, who participated remotely under traditional Brown Act rules.)

Members Absent: Jose Mayorga, M.D.

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

Vice Chair Sarmiento noted that he would be running today's meeting as Chair Becerra was participating remotely.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, welcomed everyone to the first Board meeting of the new year.

Mr. Hunn reviewed the Fast Facts, noting that CalOptima Health currently serves a little over 917,000 individuals. He reported that CalOptima Health added 8,000 members in December.

CalOptima Health's Board-designated reserves are a little over $1 billion; its capital assets are $102.1 million; its resources committed by the Board are $462.0 million; its Board-approved provider rate increases are $421.0 million; and its unallocated and unassigned resources are $402.5 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $2.5 billion.

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Mr. Hunn also added that the usual information in the Fast Facts – the personnel summary, provider network data, treatment authorization, and member demographics – are in the meeting materials.

Mr. Hunn reported that the Orange County Board of Supervisors approved the final adoption of an ordinance to allow CalOptima Health to participate in Covered California with a unanimous vote of 5-0. He thanked the 63 organizations that provided letters of support, the Hospital Association of Southern California, the Orange County Medical Association, and the Coalition of Orange County Community Health Centers that supported CalOptima Health's efforts to be able to participate in Covered California. Mr. Hunn noted that staff will work with the Board to plan, implement, and bring back for the Board's review and approval the next steps for CalOptima Health's offering on Covered California. He also stated that CalOptima Health's focus will be on those members that fall in and out of Medi-Cal eligibility on an annual basis, which will provide a cost effective, continuity-of-care option for those members.

Mr. Hunn commented on the executive orders that have caused a fair amount of confusion and concern in CalOptima Health's member communities. Mr. Hunn noted that as a health plan, CalOptima Health is bound by the Health Insurance Portability & Accountability Act, known as HIPAA; and under no circumstances will it divulge either demographic or medical information, or immigration status of any of its members, at any time, for any reason. Mr. Hunn added that CalOptima Health does not share personal identifiable information or protected health information of its members. Mr. Hunn also noted that CalOptima Health is collaborating with the Social Services Agency (SSA) and the Orange County Health Care Agency (HCA). Mr. Hunn invited Director Veronica Kelley, who is also the Director of HCA, to comment on the County's processes.

Director Kelley reminded the Board and members of the public that CalOptima Health, HCA, SSA, and other County organizations always follow the law. The County has a process in place in all its contracted clinics for addressing warrants and subpoenas. The warrants and subpoenas must be signed and be for that individual. This is not a new process for the County. The County sent out a memo to its over 400 providers, and also shared it with CalOptima Health, on what the law states and that the County follows the law. Director Kelley added that the law states the provider organizations are required to protect an individual's health information and are bound by Title 42 of the Code of Federal Regulations for substance use disorder information. However, she added that the County is seeing an increase in no shows at all its clinics, including public health clinics, immunization clinics, well-baby clinics, mental health clinics, and most alarming are no shows at its children's mental health clinics. Director Kelley reported that the County and its providers are sending communications to assure and reassure the individuals they serve and noted the partnership with CalOptima Health to provide standardized communication.

Mr. Hunn thanked Director Kelly for her comments, added that many of the County's and CalOptima Health's providers offer telehealth appointments, and encouraged members to use these types of appointments as an option. He added that baby well checks for newborns and zero to five years of age, immunizations, and developmental screenings are vital health care visits. CalOptima Health encourages families to keep those appointments.

Mr. Hunn announced that the 2025 Report to the Community is available on CalOptima Health's website and encouraged the Board, providers, and members of the community to review the information. He thanked the CalOptima Health team for the great work that went into the report.

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Mr. Hunn provided a brief update on the Naloxone Distribution project, noting that CalOptima Health is aware that 87 individuals have been saved so far by the Naloxone that has been distributed. He added that Naloxone is a safety measure and thanked the Board for approving an investment that saves lives.

Vice Chair Sarmiento thanked Mr. Hunn for his report and noted the importance of helping the community feel safe as the United States moves into this new era with a new administration. He added that many of the executive orders have created a lot of discussion and comments that are troubling for many people. Vice Chair Sarmiento suggested that CalOptima Health work closely with its legislative advocates, at both the federal and state levels, to help it understand the directions of these executive orders. He also suggested CalOptima Health consider creating a Legislative Ad Hoc Committee.

Board members and staff weighed in on the various implications of the new administration's executive orders. Several Board members were in support of creating a Legislative Ad Hoc Committee and also discussed the need for the full Board to be updated.

2. 2024 Health Equity Report

Michaell Silva Rosa, Dr.PH, LCSW, Chief Health Equity Officer, presented CalOptima Health's 2024 Health Equity Report, noting that this report highlights health equity accomplishments in five categories. The five categories are staff, members, providers, community, and systems and processes. Dr. Rose reported the accomplishments for staff include hiring a Chief Health Equity Officer, expansion of CalOptima Health's medical director team, and a dedicated position for discrimination grievances. For providers, she reported that the accomplishments include the Health Literacy Continued Medical Education, the Quality Improvement Grant Program, and Diversity, Equity, Inclusion and Belonging and Health Equity Training. The accomplishments for the community include the expansion of the Street Medicine Program, Provider Workforce Development Initiative Grants, and the Comprehensive Community Cancer Screening and Support Program. For accomplishments for systems and processes, Dr. Rose reported on the creation of an organizational Health Literacy Assessment, the creation of the Population Health Management Committee, and the organizational Assessment for Equity Infrastructure.

Dr. Rose reviewed the 2025 Health Equity Framework noting that CalOptima Health's goal is to create a more inclusive, responsive, and sustainable approach that effectively addresses the diverse health needs of its members by concentrating on five areas of focus. The five areas of focus are: (1) Reduce health disparities; (2) Leadership and advocacy for equity; (3) Member-centered care; (4) Community engagement and partnership; and (5) Empowering change through data-driven strategies.

Dr. Rose responded to Board member questions and comments.

ADVISORY COMMITTEE UPDATES

3. Member Advisory Committee and Provider Advisory Committee Updates

Christine Tolbert, Member Advisory Committee (MAC), Chair, reported on the recent and upcoming activities of the MAC and the Provider Advisory Committee (PAC). Ms. Tolbert commented on how much the members of the MAC and PAC appreciate the collaboration with CalOptima Health. She added that the MAC and PAC members have seen the shift the current leadership has with listening to their feedback and together creating fair policies and processes for CalOptima Health's members and providers.

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PUBLIC COMMENTS

- Georgina Maldonado, Community Health Initiative of Orange County: Oral report regarding budget cuts at state and federal levels.
- Eliot Krieger, Attorney for 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.
- Arnold Possick, 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.
- Christopher To, 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.
- Hieu Vo, 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.
- Son Nguyen, 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.
- Hanh Le, 360 PACE: Oral report regarding Agenda Item 10, Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County.

CONSENT CALENDAR

4. Minutes
   a. Approve Minutes of the December 5, 2024, Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the October 9, 2024, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

5. Approve Actions Related to OneCare Member Engagement and Education

6. Adopt Resolution No. 25-0206-01 Approving Updated and New CalOptima Health Human Resources Policies

7. Approve New CalOptima Health Policy DD.2014: Collection of Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Process

8. Approve New CalOptima Health Office of Compliance Policy HH.4004: Grant Auditing
This item was pulled for discussion.

9. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule Effective July 1, 2025, through December 31, 2025

10. Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County
This item was pulled for discussion.

11. Appointments to the CalOptima Health Board of Directors' Member Advisory Committee

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12. Receive and File:

a. November and December 2024 Financial Summaries
b. Compliance Report
c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 4 through 12, minus Agenda Items 8 and 10, as presented. (Motion carried 8-0-0; Director Mayorga absent)***

CONSENT CALENDAR

8. Approve New CalOptima Health Office of Compliance Policy HH.4004: Grant Auditing

Director Garcia Guillen commented that the Board Legal Ad Hoc recommends that the Board create a Grant Oversight Committee Ad Hoc, which could turn into a standing committee in the future. After considerable discussion, the Board agreed to create the Grant Oversight Committee Ad Hoc. Members of the ad hoc committee will be appointed later.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Approved new Office of Compliance Policy HH.4004: Grant Auditing. (Motion carried 8-0-0; Director Mayorga absent)***

10. Rescind the Letter of Support for 360 PACE to Offer Program of All-Inclusive Care for the Elderly Services in Orange County

After hearing public comments (noted above under Public Comment section) and a robust conversation with staff, the Board approved the action and directed staff to investigate the circumstances associated with this action and bring the results back to the Board in 30 days. The Board noted the importance of additional PACE programs in Orange County.

Action: ***On motion of Director Garcia Guillen, seconded and carried, the Board of Directors Authorized the Chief Executive Officer to rescind the letter of support provided to 360 PACE to operate a Program of All-Inclusive Care for the Elderly program in select zip codes in Orange County, independent of CalOptima Health. (Motion carried 8-0-0; Director Mayorga absent)***

REPORTS/DISCUSSION ITEMS

13. Adopt a New CalOptima Health Fiscal Year 2025-2027 Strategic Plan

The Board commended staff for all the work that went into the strategic plan.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors adopted the new CalOptima Health Fiscal Year 2025-2027 Strategic Plan. (Motion carried 8-0-0; Director Mayorga absent)***

14. Authorize Actions Related to the Medi-Cal Fee-for-Service Hospital Services Contract with HealthBridge Children's Hospital

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Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and turned off her camera and sound during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Authorized the Chief Executive Officer, or designee, to negotiate and execute a contract amendment with HealthBridge Children's Hospital effective on or after March 1, 2025, to reimburse the contracted hospital at the same All Patient Refined Diagnosis Related Groups rates and payment methodologies as other contracted fee for service hospitals, using a Board of Director-approved contract amendment. (Motion carried 7-0-0; Chair Becerra recused; Director Mayorga absent)***

15. Authorize Actions Related to the Providence Medical Foundation Medi-Cal Contract

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and turned off her camera and sound during the discussion and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved staff pursuing a shared risk group-model health network contract with Providence Medical Foundation for the Medi-Cal program, with a targeted effective date no earlier than July 1, 2025. (Motion carried 6-0-0; Chair Becerra and Director Helleland recused; Director Mayorga absent)***

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

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Authorized reallocation of $0.6 million within the Housing and Homelessness Incentive Program, Priority 1: Delivery of services and member engagement, from the consultant/continuum mapping project to the following: a.) $230,000 to the Pulse for Good contract; and b.) $370,000 to fund the provider incentives for community entities through the Pulse for Good project; and 2.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 8-0-0; Director Mayorga absent)***

17. Authorize the Chief Executive Officer to Execute a Sole Source Contract with Applied Research Works, Inc. to Acquire Data from CalOptima Health-contracted Health Networks Using Applied Research Works' Common Core of Data Files and Electronic Health Record Integration Service

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and turned off her camera and sound during the discussion and vote.

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Action: ***On motion of Director Green, seconded and carried, the Board of Directors authorized the Chief Executive Officer to negotiate and execute a sole source contract with Applied Research Works, Inc. for a two-year term with three one-year extension options, each exercisable at CalOptima Health's sole discretion, to acquire Common Core of Data files and electronic health record data for contracted health networks and CalOptima Health Community Network providers, in accordance with CalOptima Health Policy GA.5002: Purchasing Policy. (Motion carried 7-0-0; Chair Becerra recused; Director Mayorga absent)***

CLOSED SESSION

The Board adjourned to Closed Session at 3:39 p.m. Pursuant to Government Code section 54956.9(d)(2): 1 Case, CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION and Pursuant to Government Code section 54956.9(d)(4): 1 Case, CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION.

The Board returned to Open Session at 4:04 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Isabel Becerra, Chair (at 4:06 p.m.); Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting)

(All Board members participated in person, except Isabel Becerra, Chair, who participated remotely under traditional Brown Act rules.)

Members Absent: Jose Mayorga, M.D.

CLOSED SESSION

Vice Chair Sarmiento noted that the Board met in Closed Session and there were no reportable actions taken.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members thanked staff for their work.

Director Byron wished her husband a Happy Anniversary.

Director Helleland appreciated CalOptima Health's proactive communication.

Director Kelley thanked CalOptima Health for its compassion.

Supervisor Chaffee reported that there will be extended hours on Valentine's Day for anyone wishing to reaffirm their vows or plan to get married on February 14, 2025. He also noted that the Fourth District will be hosting a Fishing Derby at the end of March.

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Vice Chair Sarmiento noted that the Second District is hosting a webinar on February 10, 2025, at 5:00 p.m., titled, "Know Your Rights" for anyone that would like information on how recent executive orders may affect individuals and families.

ADJOURNMENT
Hearing no further business, Vice Chair Sarmiento adjourned the meeting at 4:11 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 6, 2025

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 21, 2024

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on November 21, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Blair Contratto, Acting Chair, called the meeting to order at 3:00 p.m., and led the Pledge of Allegiance.

ROLL CALL

Members Present:	Blair Contratto, Acting Chair; Brian Helleland (All members participated in person)
Members Absent:	Isabel Becerra, Chair
Others Present:	Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Sharon Dwiers, Clerk of the Board

The Clerk noted that no changes were made to the agenda.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided two verbal updates for the meeting. The first update included the Calendar Year (CY) 2025 capitation rates from the Department of Health Care Services (DHCS), the second update was related to the state's recent reconciliation of Proposition 56 direct payments.

For the first update, Ms. Huang began with the CY 2025 Medi-Cal draft rates from DHCS. After reviewing the draft rates, staff found areas of concern. Specifically, staff was concerned with (i) the significant underfunding for CalAIM Community Support Services, (ii) insufficient funding for CalOptima Health's Targeted Provider Rate increase for phase one, and (iii) issues with the trend assumptions in the calendar year 2025 rates compared to actual reported experiences. Ms. Huang stated that CalOptima Health provided feedback to the DHCS contract manager. She added that CalOptima

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Health is working in collaboration with the Local Health Plans of California (LHPC) to seek corrections to the significantly underfunded areas in DHCS' rates.

For the second update, Ms. Huang reported that after reviewing the CY 2022 Proposition 56 reconciliation from DHCS, staff identified gaps between CalOptima Health's internal records and DHCS' allowable expenses. Ms. Huang confirmed that staff is addressing these issues with affected networks and providers. She noted that adjustments may be needed based on these findings and that staff will keep the Board updated.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that CalOptima Health has experienced zero major cybersecurity incidents in the previous quarter. However, Mr. Steele noted that CalOptima Health experienced one notable third-party incident involving College Hospital in quarter 3 of 2024. Mr. Steele confirmed that the incident was under investigation, and while it did not directly compromise CalOptima Health's systems, Mr. Steele highlighted the need for ongoing third-party risk management.

Additionally, Mr. Steele updated the committee about relevant cyber security news, cyber security metrics, and the Centers for Medicare & Medicaid Services' and the Health and Human Services' expectations for security controls and artificial intelligence governance.

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of July 1, 2024, through September 30, 2024. The portfolio totaled approximately $3.4 billion. Of the total portfolio amount, $2.3 billion was in CalOptima Health's operating account and approximately $130 million was included in its statutory designated reserve fund to meet the tangible net equity requirements.

Ms. Huang reported that Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

Ms. Huang responded to committee members' comments.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the September 19, 2024, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the July 22, 2024, Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Helleland, seconded and carried, the committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Chair Becerra absent)***

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REPORTS/DISCUSSION ITEMS

5. Recommend That the Board of Directors Ratify the Acceptance, Receipt and Refiling of the Revised Fiscal Year 2023-24 CalOptima Health Audited Financial Statements

Ms. Huang provided an update regarding CalOptima Health's Fiscal Year (FY) 2023-24 consolidated audited financial statements submitted by independent auditor Moss Adams, LLP. She stated that following further review, Moss Adams identified one formula error in the FY 2023-24 (prior year) column in the audited financial statement package. The error incorrectly presented CalOptima Health's "Net investment in capital assets" and "Unrestricted" net position on pages 4, 6, and 24 of the audited financial statements. Ms. Huang stated that the correction was made and CalOptima Health worked with Moss Adams to submit the revised audited financial statements to the Department of Managed Health Care by the October 31, 2024, deadline.

Action: ***On motion of Director Helleland, seconded and carried, the committee recommended that the CalOptima Health Board of Directors ratify the acceptance, receipt, and refiling of the revised fiscal year 2023-24 CalOptima Health consolidated audited financial statements as resubmitted by independent auditor, Moss Adams, LLP. (Motion carried 2-0-0; Chair Becerra absent)***

6. Recommend that the Board of Directors Approve Modifications to Policy GA.3400: Annual Investments.

Action: ***On motion of Director Helleland, seconded and carried, the committee recommended that the Board of Directors approve modifications to the CalOptima Health Policy GA.3400: Annual Investments. (Motion carried 2-0-0; Chair Becerra absent)***

The following items were accepted as presented.

INFORMATION ITEMS

7. September 2024 Financial Summary

8. Quarterly Operating and Capital Budget Update

9. CalAIM Program Summary

10. Quarterly Reports to the Finance and Audit Committee
    a. Net Asset Analysis
    b. Enrollment Trend Report
    c. Shared Risk Pool Performance Update
    d. Health Network Financial Compliance Review Update

COMMITTEE MEMBER COMMENTS

There were no committee member comments.

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ADJOURNMENT

Hearing no further business, Acting Chair Contratto adjourned the meeting at 3:29 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 20, 2025

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve New CalOptima Health Policy EE. 1145: Prospective Health Network

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Approve new CalOptima Policy EE.1145: Prospective Health Network, effective March 6, 2025.

Background

CalOptima Health currently has nine (9) delegated Health Networks that provide covered services to over seven hundred thousand (700,000) CalOptima Health members. For purposes of the new policy, the definition of a Health Network is an entity that is contracted with CalOptima Health to provide covered services through a health care service plan such as a Health Maintenance Organization (HMO) subcontractor, or a physician group under a shared risk (SRG) agreement.

Discussion

Over the past year, CalOptima Health received inquiries from entities interested in becoming a Health Network. After careful review of existing policies, leadership recognized the need to establish a new policy to ensure a fair and equitable review process for applying and becoming a Health Network.

CalOptima Health establishes new policies and procedures to implement federal and state laws, program regulations, contracts, and business practices. The purpose of Policy EE.1145: Prospective Health Network is to outline the criteria a prospective Health Network must meet for consideration. The policy also outlines CalOptima Health's review process and readiness assessment activities to evaluate the prospective Health Network.

Fiscal Impact

The recommended action to approve new CalOptima Policy EE.1145 is operational in nature. As Health Networks are added to CalOptima Health's delivery system, staff will evaluate and incorporate any changes through separate Board actions and/or future operating budgets.

Rationale for Recommendation

Approval of this new policy EE.1145: Prospective Health Network is recommended to ensure CalOptima Health's commitment to conducting its business in a fair and equitable manner.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Policy EE. 1145: Prospective Health Network

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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Policy:	EE.1145
Title:	**Prospective Health Network**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/*
Effective Date:	03/06/2025
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the criteria to add a prospective Health Network to CalOptima Health. To be considered, the applicant must fulfill all the requirements stated in this policy.

II. POLICY

A. The prospective Health Network must meet all the criteria included in this policy:

1. Contract with a minimum of twenty-five (25) new Primary Care Providers (PCPs) not contracted with CalOptima Community Network (CCN) or an existing health network contracted with CalOptima Health;

2. Have a robust provider network in Orange County that meets provider network adequacy standards including access and availability for Medi-Cal and Medicare Dual Special Needs Plan (D-SNP) enrollees;

3. Demonstrated experience managing delegated risk;

4. Be registered with the Department of Managed Health Care (DMHC) as a Risk Bearing Organization (RBO);

5. Has no open deficiencies or corrective actions with DMHC;

6. Pass a network solvency review audit conducted by CalOptima Health;

7. Accepts claims, credentialing, and utilization management delegated functions, in accordance with CalOptima Health's policies and requirements;

8. Has subcontracted Providers with hospital admitting privileges at CalOptima Health's contracted hospitals;

9. Must not be excluded or precluded from participating in a federally funded healthcare program (e.g., Medicaid/Medi-Cal, Medicare);

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10. Provide services for all age-ranges; and

11. Achieve and maintain enrollment of a minimum of 5,000 Members within thirty-six (36) months from the effective date of becoming a Health Network in accordance with CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment.

B. The prospective Health Network must execute a Medi-Cal and OneCare Contract for Health Care Services by selecting one of the contract models defined in section II.C. subject to CalOptima Health's discretion, network strategy, and the successful completion and approval of a Readiness Assessment including a pre-delegation review and implementation requirements.

C. The prospective Health Network has the option of two Contract Models:

1. Shared Risk (SRG)

2. Global Risk/Full Risk (HMO)

D. Entities that submit a contracting request are not guaranteed approval to contract with CalOptima Health.

1. CalOptima Health reserves the right to deny any contracting request from an entity seeking to contract as a new Health Network at its sole and absolute discretion. Nothing in this Policy is intended to indicate the entity requesting a contract with CalOptima Health as a Health Network is guaranteed to be approved.

E. Entities seeking to contract with CalOptima Health as a new Health Network must participate in all CalOptima Health programs offered and may apply to contract under a different contract model for each program, subject to CalOptima Health's discretion and approval.

F. Entities seeking to contract with CalOptima Health as a new Health Network must submit all required documents for review and approval and shall meet all CalOptima Health operational requirements and applicable state and federal requirements under the requested contract model.

G. Entities seeking to contract with CalOptima Health as a new Health Network must meet the designated timeframes, as outlined in CalOptima Health Policy GG.1619: Delegation Oversight, for readiness assessment and implementation unless an extension request is approved by CalOptima Health.

H. Entities seeking to contract with CalOptima Health as a new Health Network must fulfill all licensure, pre-evaluation, Readiness Assessment, policy review, contractual, and regulatory requirements to contract with CalOptima Health under the requested contract model for the respective line(s) of business.

I. If approved by CalOptima Health as a new Health Network, the new Health Network for the duration of the contract is required to notify CalOptima Health of any assignment changes including:

1. The change of more than fifty percent (50%) of the directors or trustees of;

2. The merger, reorganization, or consolidation of the Health Network with another entity when the Health Network is not the surviving entity; or

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3. A change in the management of the Health Network from the management by persons appointed, elected or otherwise selected by the governing body of the Health Network (e.g., the Board of Directors) to a third-party management person or entity. In addition, the Health Network must obtain CalOptima Health's prior written consent for any change of control. For purposes of this policy, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in the Health Network (whether in a single transaction or in a series of transactions).

J. New Health Network contracts are subject to approval by the CalOptima Health Board of Directors.

III. PROCEDURE

A. Submission and Review of Contracting Request and Required Applications and Documents

1. Prospective Health Networks seeking to contract with CalOptima Health must submit a written Letter of Intent (LOI) to the Executive Director of Network Operations via email or other written form signed and dated by Chief Executive Officer, or designee, that has been granted authority to make decisions on behalf of the prospective Health Network. The CalOptima Health Executive Director of Network Operations shall review the request within fifteen (15) business days of receipt of the prospective Health Network's LOI. The Executive Director will send a written response informing the prospective Health Network of the requirements to move forward with the application process.

B. Initial Review

1. Upon receipt of initial application, CalOptima Health shall verify the prospective Health Network is not excluded or precluded from participating in a federally funded healthcare program (e.g., Medicaid/Medi-Cal, Medicare), as outlined in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Upon verifying the prospective Health Network is not excluded or precluded from participating in a federally funded healthcare program, the prospective Health Network's LOI proposal and initial application will be reviewed.

3. If the documentation does not meet the requirements, the CalOptima Health Executive Director of Network Operations shall notify the applicant of the decision.

C. CalOptima Health Review Team

1. If the prospective Health Network meets the requirements and all required documentation is received, the Executive Director of Network Operations shall forward the prospective Health Network application packet to the CalOptima Health review team. The team will review and score the documents in accordance with the instructions on the scoring tool. The CalOptima Health review team will review and tally the scores and will make a recommendation. Based on their recommendation, the documents will be sent to CalOptima Health's Delegation Oversight Department to conduct the Readiness Assessment.

D. Readiness Assessment Activities

1. Following approval to move forward from the CalOptima Health review team, the Executive Director of Network Operations, and the CalOptima Health Contracting Department will pursue contract(s) with the prospective Health Network.

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CalOptima Health's Delegation Oversight Department shall conduct a Readiness Assessment including a pre-delegation review of the prospective Health Network and present the findings of the Readiness Assessment to CalOptima Health's Compliance Committee, as outlined in CalOptima Health Policy GG.1619: Delegation Oversight.

2. CalOptima Health will assign project management resources to develop a project plan and workgroup comprised of CalOptima Health departments to implement the onboarding of a new Health Network.

   i. The CalOptima Health workgroup shall monitor deliverables and milestones for the onboarding of the new Health Network contract, in partnership with other functional areas within CalOptima Health. Regular meetings will be established with the new Health Network entity and the CalOptima Health workgroup.

   ii. Within sixty (60) calendar days of the proposed effective date or change, CalOptima Health shall submit to the Department of Health Care Services (DHCS) the proposed delegation and a copy of the proposed delegates compliance plan utilizing the DHCS template which includes but is not limited to:

      a) All CalOptima Health's contractual relationships with Subcontractor and Downstream Subcontractors;

      b) CalOptima Health's oversight responsibilities for all delegated obligations; and

      c) How CalOptima Health intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

   iii. CalOptima Health's Contracting Department will coordinate with CalOptima's Regulatory Affairs & Compliance Department to submit a copy of the new proposed Health Network contract to DHCS at least sixty (60) calendar days prior to the proposed contract effective date if there are significant changes to the contract template approved by DHCS.

3. Once the prospective Health Network has met all necessary readiness requirements, and both CalOptima Health and the Health Network have agreed to contract language, terms and rates, CalOptima Health's Executive Director of Network Operations shall present the findings to CalOptima Health's Executives.

4. Executive leaders will present a CalOptima Health Board Action Referral (COBAR) to the CalOptima Health Board of Directors for approval. The Board of Directors may approve subject to approval by DHCS.

5. Upon CalOptima Board approval, the contract will be submitted for full execution by CalOptima Health and the Health Network.

IV. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

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D. CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment
E. CalOptima Health Policy EE.1141: CalOptima Provider Contracts
F. CalOptima Health Policy GG.1619: Delegation Oversight
G. CalOptima Health Policy HH.2005: Corrective Action Plan
H. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.
I. CalOptima Health DHCS D-SNP Contract/State Medicaid Agency Contract (Exclusively Aligned Enrollment (EAE) SMAC)
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
K. Prospective Health Network Packet
L. Title 28, California Code of Regulations (CCR), Section 1300.51
M. Title 42, Code of Federal Regulations (CFR), Section 438.3 – Standard Contract Requirements

V. REGULATORY AGENCY APPROVAL(S)

None to Date

VI. BOARD ACTION(S)

Date	Meeting
03/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/06/2025	EE.1145	Prospective Health Network	Medi-Cal OneCare

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VIII. GLOSSARY

Term	Definition
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's, or other contracted entity's, Contract with CalOptima Health of the Health Networks, or contracted entity's, compliance with all or a specified number of operational functional areas as determined by CalOptima Health.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve New CalOptima Health PACE Policy PA.2003: PACE Palliative Care

Contacts

Javier Sanchez, Executive Director, Operations Management, (714) 986-6115
Monica Macias-Garcia, LCSW, PACE Director, (714) 468-1077

Recommended Actions

Approve new policy PA.2003: PACE Palliative Care to comply with regulatory requirements.

Background

Approve new CalOptima Health policy PA.2003: PACE Palliative Care for CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) to meet regulatory requirements.

Discussion

CalOptima Health PACE regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements and contractual obligations. Staff proposes a new policy, PA.2003: PACE Palliative Care, to meet the requirements of Welfare & Institutions Code § 14132.75, Department of Health Care Services All Plan Letter 18-020: Palliative Care, and Title 42 Code of Federal Regulations § 460.112. Together, the requirements mandate that CalOptima Health ensure access to palliative care services for individuals with serious illnesses and provide guidance for implementing palliative care.

To meet palliative care service requirements, policy PA.2003: PACE Palliative Care establishes requirements for palliative care services that ensure access for individuals with serious illnesses. The policy also specifies eligible conditions, covered services, and coordination requirements.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

Approval of CalOptima Health PACE Policy PA.2003 ensures CalOptima Health meets regulatory requirements for palliative care services provided to PACE participants.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. CalOptima Health PACE PA.2003 PACE Palliative Care

/s/ Michael Hunn *02/27/2025*

Authorized Signature **Date**

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Policy:	PA.2003
Title:	**PACE Palliative Care**
Department:	CalOptima Health Pace
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope and services of the Palliative Care Program for CalOptima Health Program of All-Inclusive Care for the Elderly ("PACE") Participants.

II. POLICY

A. CalOptima Health PACE shall provide Palliative Care services to Participants as outlined in this policy, Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) contractual requirements and the Centers of Medicare and Medicaid Services (CMS).

B. CalOptima Health PACE shall ensure that the Participant or Authorized Representative receive information, in writing, and fully understand, Palliative Care, comfort care, or end of life care services as described in Title 42 Code of Federal Regulations (CFR) §460.112, before implementation by CalOptima Health PACE.

1. CalOptima Health PACE shall identify all services that are impacted and provide a detailed explanation of how the services will be impacted if the Participant or Authorized Representative elects to initiate Palliative Care, comfort care, or end-of-life care, including but not limited to the following types of services:

   a. Physician services, including specialist services;

   b. Hospital services;

   c. Long-term care services;

   d. Nursing services;

   e. Social services;

   f. Dietary services;

   g. Transportation;

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h. Home care;

i. Therapy, including physical, occupation, and speech therapy;

j. Behavioral health;

k. Diagnostic testing, including imaging and laboratory services;

l. Medications;

m. Preventative healthcare services; and

n. PACE center attendance.

C. CalOptima Health PACE shall provide Medically Necessary Palliative Care services to Participants who satisfy the minimum eligibility requirements described in Section III of this Policy.

D. If the Participant continues to meet the minimum eligibility requirements, the Participant can continue to receive both Palliative Care and Curative Care until their condition improves, stabilizes, or results in death.

E. Palliative Care services shall include the following coordination of care.

1. Advanced Care Planning, which includes documentation of discussions between the Provider and the Participant or Authorized Representative. Discussion and planning shall address the Participant's Advance Directives, such as their Physician Orders for Life-Sustaining Treatment (POLST).

2. Palliative Care assessment and consultation (can be done at the same time of the Advanced Care Planning stage). The discussion should include all of the information regarding the CalOptima Health PACE Palliative Care program, and may include but is not limited to:

a. Treatment plan for Palliative Care.

b. Pain and medication effects.

c. Emotional and social challenges.

d. Spiritual concerns.

e. Participant goals.

f. Advanced Directives; POLST

g. Legally recognized decision maker.

3. The Interdisciplinary Team (IDT) must develop and update the Participant's Plan of Care to reflect the Palliative Care services. The IDT shall provide all authorized services within the timeframes noted in CalOptima Health Policy PA.1007: Delivery of PACE Services as outlined in Title 42 C.F.R. §460.98.

4. Care coordination to ensure continued oversight of provided services and continued need for Palliative Care.

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5. Pain management as authorized by the IDT, which may include prescription drugs and physical therapy to help manage Participant's pain needs.

6. Mental health services to support Participants with their psychosocial needs that may arise from serious illness and the dying process. This could include psychotherapy, bereavement counseling, and discharge planning.

F. CalOptima Health PACE shall assess Palliative Care needs as deemed necessary or during the Participant's assessment cycle. CalOptima Health may discontinue Palliative Care services that are no longer Medically Necessary or reasonable, or at the request of the Participant or Authorized Representative.

III. PROCEDURE

A. Minimum Eligibility Criteria

1. CalOptima Health PACE Participants are eligible to receive Palliative Care services if they meet all the of criteria outlined in Section III.A.2., and at least one of the four requirements in Section III.A.3 of this Policy.

2. General Eligibility Criteria

a. The Participant is likely to or has started to use the hospital or emergency department to manage their advanced disease (unanticipated decompensation and not including elective procedures).

b. The Participant has an advanced illness as outlined in Section III.A.3. of this Policy with appropriate documentation of continued deterioration in health status and is not eligible for or declines hospice enrollment.

c. The Participant's death within a year would not be unexpected based on clinical status.

d. The Participant has either received appropriate patient-desired medical therapy or is a Participant for whom patient-desired medical therapy is no longer effective. The Participant is not in reversible acute decompensation; and

e. The member and, if applicable, the family/member-designated support person, agrees to:

i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and

ii. Participate in Advance Care Planning discussions.

3. Disease-Specific Eligibility Criteria

a. Congestive Heart Failure (CHF) with both:

i. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

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ii. An ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

b. Lung Disease

i. Chronic Obstructive Pulmonary Disease (COPD)

a) Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

b) Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

ii. Other lung disease such as but not exclusive to Interstitial Lung Disease or Pulmonary Hypertension

a) Recurrent lung infections, increased dyspnea on exertion, FVC in 1 second <1 liter, oxygen saturation of <88% at room air at rest, hypercapnia PCO2>49 mmHG, weight loss >10% over preceding 6 months, or resting HR >100/min.

c. Advanced cancer with both:

i. Stage III or IV solid organ cancer, lymphoma or leukemia; and

ii. A Karnofsky Performance Scale (KPS) score less than or equal to seventy (70) or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

d. Liver disease with:

i. Evidence of irreversible liver damage, serum albumin less than 3.0 and International Normalized Ratio (INR) greater than 1.3, and

ii. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

iii. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

iv. To calculate MELD Score, visit the Health & Human Services Administration (HRSA) website: https://optn.transplant.hrsa.gov/data/allocation-calculators/meld-calculator/.

e. End Stage Renal Disease

i. Stage V Chronic Kidney Disease with Glomerular filtration rate (GFR) <15 ml/min; and

ii. Participant declines to start hemodialysis or decides to stop current hemodialysis.

f. Parkinson's Disease:

i. Stage IV of Parkinson's with severely disabling disease (nutritional impairment resulting in Body Mass Index (BMI) <18 or 10% weight loss and refusal of artificial

feeding methods, multiple falls, falls with fracture, infections, motor symptoms poorly responsive to medications, worsening dementia); or

ii. Stage V of Parkinson's with confinement to bed or wheelchair unless aided.

g. Dementia:

i. Stage 5, 6 or 7 on the Functional Assessment Staging Test (FAST) scale; and

ii. Patients have had one of the following secondary conditions within the past twelve (12) months:

a) Delirium;

b) Recurrent or intractable infections, such as pneumonia or other URI;

c) Pyelonephritis or other urinary tract infection;

d) Septicemia;

e) Decubitus ulcers, multiple stages 3-4; or

f) Inability to maintain sufficient fluid and calorie intake demonstrated by either of the following: 10% weight loss during the previous six months OR Serum albumin <2.5 gm/dl.

h. Cerebrovascular Disease

i. Diagnosis with one of the following: stroke, carotid stenosis, vertebral stenosis and intracranial stenosis, aneurysms, and vascular malformations; and

ii. Palliative Performance Scale (PPS) score of ≤ 60%.

B. Palliative Care Review and Consent Process

1. Participants who are identified to meet the eligibility criteria for Palliative Care Services will be identified by the CalOptima Health PACE IDT.

2. Participants who are identified to meet the eligibility criteria will have a Palliative Care consultation meeting with the CalOptima Health PACE Social Worker and Primary Care Provider to review the PACE Palliative Care Consent Form (Attachment A of this policy).

3. The Participant or Authorized Representative must make the decision to receive Palliative Care services. They also have the right to revoke or withdraw their consent to receive Palliative, comfort, or end-of-life care at any time and for any reason, either verbally or in writing.

4. If the Participant or Authorized Representative agrees to Palliative Care services, the Social Work Department and Primary Care Provider will review the consent form with them in detail and ensure the Participant understands the services that are rendered under the PACE Palliative Care program. If the Participant or Authorized Representative agrees, they will sign the consent form.

5. The IDT will review the Participant's care needs and add services into the care plan.

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6. The Palliative Care Consent Form will be scanned and uploaded to the EMR.

7. The CalOptima Health PACE IDT is responsible for coordinating, authorizing and monitoring Palliative Care services.

IV. ATTACHMENT(S)

A. CalOptima Health PACE Palliative Care Consent Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for the PACE Program
B. CalOptima Health Policy PA.1007: Delivery of Services
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care
E. Department of Health Care Services (DHCS) SB 1004 Medi-Cal Palliative Care Policy, November 2017 – Update
F. Senate Bill 1004 (SB 1004)
G. Title 42, Code of Federal Regulations (C.F.R.) §§460.96, 460.98, 460.112
H. Welfare and Institutions Code (WIC) § 14132.75

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services	TBD

VII. BOARD ACTION(S)

Date	Meeting
03/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	PA.2003	PACE Palliative Care	PACE

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IX. GLOSSARY

Term	Definition
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the Participant is incapacitated.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Interdisciplinary Team (IDT)	A team composed of Participants qualified to fill, at minimum, the following Participant roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following: a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's – level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or his or her representative; and Driver or his or her representative
Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

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Term	Definition
Palliative Care	Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.
Participant	An individual enrolled in the CalOptima Health PACE program.
Physician Orders for Life-Sustaining Treatment (POLST)	A tool for end-of-life planning. It ensures that a patient's treatment wishes are known and will be followed by health care professionals during a medical crisis, when the patient cannot speak for themselves.
Plan of Care	A comprehensive care plan developed by the interdisciplinary team for each participant to identify the care needed to meet the medical, physical, emotional, and social needs of the participant, as identified in the initial comprehensive assessment.
Primary Care Provider (PCP)	A provider responsible for supervising, coordinating, and providing initial and Primary Care to Participants; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Program of All-Inclusive Care for the Elderly ("PACE")	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

1

CalOptima Health PACE Palliative Care

CalOptima Health PACE gives all participants the choice to receive palliative care at any time during their enrollment with our program.

What is palliative care?

Palliative care helps to prevent and ease pain while supporting the best quality of life for participants with a serious or life-threatening illness. It also helps support their families. Using a palliative care approach at PACE can make a participant's quality of life better while avoiding medical treatments that are not needed and could be harmful.

What services will change if I sign up for palliative care at PACE?

Since palliative care focuses on easing pain and reducing procedures that are not needed, signing up for palliative care means you agree to certain changes in your health care. This type of care is about keeping you comfortable and making your quality of life better when you have a serious illness. By signing up for palliative care, you are telling us that you wish to make these changes. Here's what this means for your services:

1. Lab/Blood Draws: You won't have blood testing done as part of preventive health screening, like testing your cholesterol levels to prevent future health issues. You will still have lab/blood draws to test for illnesses that need quick treatment to ease pain.

2. EKG, bone density, ultrasound, CT scan or MRI: You won't have these types of exams often to diagnose and prevent illness. They will only be done as part of emergency care.

3. Elective Procedures: You won't have elective procedures such as colonoscopies or surgeries.

4. Vaccinations: You won't receive annual vaccines that could prevent or lessen symptoms of viral or bacterial infections such as the flu or COVID-19.

5. Rehabilitation Services: You won't take part in preventative rehab services that focus on strength, fall prevention, and/or activities of daily living. You can still receive Rehab services that help manage pain to support comfort care.

6. Emergency Evaluations: You agree to talk to PACE about your choices and understand going to the emergency room or being hospitalized might not fit with your care goals.

7. Specialist Appointments: You won't be scheduled for routine checkups with specialists like cardiologists, neurologists or ophthalmologists.

8. Dietary Recommendations: You won't need to follow special diet plans, like a low-fat or low-sodium diet.

9. Behavioral Health: You will stop receiving behavioral counseling for past traumatic experiences. You still get behavioral health services to help with grief or loss related to a current life-threatening illness to support your mental health.

10. Medications: You will stop receiving medications intended to extend your life and will receive medications focused on minimizing pain and discomfort. Your exact medicine regimen will be decided between you and your provider.

The following services will not be affected by choosing palliative care: long-term care services, nursing services, social services, transportation, home care, or PACE center attendance.

By signing below, I agree that I fully understand CalOptima Health PACE's palliative care program and agree to the information above regarding my care and treatment at PACE. I understand that I can change my mind at any time and can go back to receiving full PACE services, including preventive health screenings and treatments. My care team may also decide I no longer meet the medical eligibility requirements for palliative care services.

_____ _____

Participant or Authorized Representative Date

_____ _____

CalOptima Health PACE Interdisciplinary Team Staff Date

Enclosures:

- Notice of Availability and NOND Insert [Material ID: <H7501_25IRMM001_C>]

CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational Vendor Health Management Systems, Inc.

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Authorize the Chief Executive Officer to execute an amendment to extend the contract with Health Management Systems, Inc. under the same terms and conditions for two additional one-year extensions, effective May 15, 2025, at CalOptima Health's discretion.

Background

On December 1, 2022, the Board of Directors (Board) approved an extension of two years for Health Management Systems, Inc. (HMS).

HMS performs other health coverage (OHC) review and detection of potential primary benefit coverages through other health plans. The service includes identifying and recovering overpayments directly from primary commercial plans due to OHC for CalOptima Health Direct, and CalOptima Health Community Network members. HMS has the expertise and technology to detect and/or identify OHC using CalOptima Health's claims paid data. Once OHC is identified, HMS initiates the recovery process by billing the appropriate health plan as part of the vendor recovery solution. Additionally, HMS performs OHC review of claims that were adjudicated without the Coordination of Benefits (COB) indicator based on the eligibility file received from the Department of Health Care Services (DHCS). These overpayment recoveries are requested directly from our network providers. HMS has provided recovery services for CalOptima Health through a post-payment solution since May 15, 2008.

Discussion

HMS has established strong working relationships with both CalOptima Health and, crucially, CalOptima Health's provider community. The vendor is in full compliance with DHCS guidelines and regulatory requirements, consistently surpassing expectations by meeting 100% of all annual audit requirements and not receiving a corrective action plan in any of the audit areas.

The contracted vendor has performed well during external audits. There has been no cost avoidance and OHC post-payment services or process deficiency in recent annual DHCS audits.

Additionally, CalOptima Health's Audit & Oversight (A&O) Department conducts an annual audit on all contracted vendors to monitor and ensure that CalOptima Health functions are performed satisfactorily for all lines of business. The vendors are evaluated based upon CalOptima Health's requirements, as well as Centers for Medicare & Medicaid Services and DHCS regulatory requirements. The contracted vendor has performed well in the annual audits and worked cooperatively with the A&O

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Department to provide its policies and procedures and has been transparent with its systems and operations.

The HMS contract expires on May 14, 2025. HMS is one of the well-known and proven OHC vendors within the industry. Other managed care plans, including CalOptima Health, are either transitioning to or have already been engaged with HMS due to its expertise in COB recoveries and OHC, which adhere to regulatory guidelines and ensure compliance with Medi-Cal. HMS's services are also used by DHCS for cost avoidance and OHC post-payment services. Staff requests extending the contract for an additional two one-year extensions through May 14, 2027.

The contract with HMS is based on a 23% contingency fee for the recovered improper claim payments related to COB. In Calendar Year (CY) 2023 and CY 2024, CalOptima Health paid approximately $4 million to HMS in contingency fees for COB and OHC services. During the same period, CalOptima Health received $13.4 million in total net recoveries. The contracted contingency percent rate is on the lower bracket of the industry standard of 20% to 50%. In addition to its recovery services, HMS is providing CalOptima Health with the necessary reporting required by DHCS for cost avoidance and OHC post-payment recovery.

HMS is following current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact
The HMS contract is a budgeted item in the CalOptima Health Fiscal Year 2024-25 Operating Budget. The annual fiscal impact is approximately $1.7 million. Management will include expenses related to the extension periods on and after July 1, 2025, in future operating budgets.

Rationale for Recommendation
Extending this contract will ensure the continued, uninterrupted provision of services and the seamless processing of claims payment to CalOptima Health's providers while allowing staff to work on other regulatory deliverables and critical projects.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Contracted Entity Covered by this Recommended Board Action
2. Previous Board Action dated December 1, 2022, "Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc."

/s/ Michael Hunn *02/28/2025*
Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Systems Inc.	9020 Stony Point Parkway Suite 165	Richmond	VA	23235

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc.

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

Authorize the Chief Executive Officer to amend and extend the contracts, under the current terms and conditions, for an additional two years with the following vendors:

a. Office Ally Inc., for front-end claims electronic data interchange clearinghouse services, for a contract extension of two-year extension from January 1, 2024, through December 31, 2025;
b. Change Healthcare Technologies LLC, formerly Emdeon, for claims electronic data interchange clearinghouse services, for a contract extension of two-years from January 1, 2024, through December 31, 2025; and
c. Health Management Systems Inc., for coordination of benefits recovery cost containment services, for a contract extension of two-year from May 15, 2023, through May 14, 2025.

Background

Office Ally Inc. (Office Ally) is one of the claims administration clearinghouses that interacts with providers to submit claims electronically to CalOptima Health for payment consideration. Once the claims are submitted to Office Ally, Office Ally sends the claim files to CalOptima Health for processing. Office Ally has provided CalOptima Health electronic data interchange (EDI) clearinghouse services since July 1, 2004.

Change Healthcare Technologies LLC (Change) is a secondary EDI clearinghouse for providers to submit long-term care and facility claim types. Change has provided CalOptima Health with EDI clearinghouse services since October 12, 2000.

Health Management Systems Inc. (HMS) performs other health coverage (OHC) review and detection of potential primary benefit coverages through another health plan. This service includes identifying and recovering overpayments due to OHC for CalOptima Health Direct (COD) and CalOptima Health Community Network (CCN) members. HMS has the expertise and technology to detect and/or identify OHC using CalOptima Health's claims file. Once OHC is identified, HMS initiates the recovery process by billing the appropriate health plan as part of the vendor recovery solution. Additionally, HMS performs OHC review of claims that were adjudicated without the COB indicator or segment based on the eligibility file received from the Department of Health Care Services (DHCS). These overpayment recoveries are requested directly from CalOptima Health's network providers. HMS has provided recovery services through a post-payment solution since May 15, 2008.

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Discussion

All three vendors listed above have established a good working relationship with CalOptima Health and, most importantly, CalOptima Health's provider community. Replacing these providers would require significant data mapping and logic changes from CalOptima Health. Changing clearinghouse vendors would also impact the provider community, as most of CalOptima Health's providers are currently contracted with Office Ally and Change Healthcare.

The Office Ally contract expires on December 31, 2023. By extending the contract term to add two years, beginning January 1, 2024, CalOptima Health will be able to maintain current business operations without disrupting and impacting CalOptima Health's providers' ability to submit their claims electronically.

The Change contract expires on December 31, 2023. By extending the contract term to add two years, beginning January 1, 2024, CalOptima Health will eliminate transitional costs of a new vendor without disrupting the current adjudication workflow or delaying payment to providers. Additionally, Change will upgrade the current file submission by adding a feature and automation that will allow CalOptima Health to redirect claims billed to the incorrect health network through electronic file routing. This will eliminate the need for CalOptima Health claims administration staff to manually print and send specific misdirected claims to the appropriate health network based on division of financial responsibility.

The HMS contract expires on May 14, 2023. Staff recommends amending and extending the contract term to add two years, beginning May 15, 2023. HMS is a contingency contract at 23% from the net recovered overpayments for improper claims payments related to COB. The overall recovery savings from January 2021 to September 2022 are $3,762,041. In addition to the recovery solution, HMS is providing CalOptima Health the necessary reporting required by DHCS as it relates to cost avoidance and post-payment recovery for OHC.

Fiscal Impact

The CalOptima Fiscal Year 2022-23 Operating Budget included the annual fees for the listed contracted vendors through June 30, 2023. Specifically, the budget included the following amounts: approximately $1.1 million for Office Ally, $580,000 for Change, and $900,000 for HMS. Management will include expenses for the recommended contract extension periods on or after July 1, 2023, in future operating budgets.

Rationale for Recommendation

Extension of these contracts will ensure there is no disruption to the services provided by these solutions and the continuation of appropriate claims payment to CalOptima Health's providers.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by This Recommended Board Action
2. MC 03193 HMS Contract
3. MC 03193 HMS Amendment 1
4. MC 03193 HMS Amendment 2
5. MC 03193 HMS Amendment 3
6. MC 03193 HMS Amendment 4
7. CalOptima Health HMS Post-Close Letter
8. Change Healthcare Payer Agreement
9. Change Healthcare Payer Amendment 1
10. Change Healthcare Payer Amendment 2
11. Mc 03299 Office Ally Contract
12. Mc 03299 Office Ally Amendment 1
13. Mc 03299 Office Ally Amendment 2
14. Mc 03299 Office Ally Amendment 3
15. Mc 03299 Office Ally Amendment 4
16. Mc 03299 Office Ally Amendment 5
17. Mc 03299 Office Ally Amendment 6
18. Mc 03299 Office Ally Amendment 7
19. Mc 03299 Office Ally Amendment 8
20. Mc 03299 Office Ally Amendment 9
21. Mc 03299 Office Ally Amendment 10
22. Mc 03299 Office Ally Amendment 11
23. Mc 03299 Office Ally Amendment 12

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
March 5, 2020	Approved	3-year contract extension	N/A

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Office Ally	1300 SE Cardinal Court Suite 190	Vancouver	WA	98683
Change Healthcare Technologies, LLC	424 Church Street	Nashville	TN	37219
Health Management System (HMS)	9020 Stony Point Parkway Suite 165	Richmond	VA	23235

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CONTRACT NO. MC 03193

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

HEALTH MANAGEMENT SYSTEMS, INC.

(VENDOR)

THIS CONTRACT is entered into as of May 15, 2008, by and between the Orange County Health Authority, a Public Agency, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("CalOptima"), 1120 West La Veta Avenue, Orange, CA 92868, and Health Management Systems, 1000 S. Fremont Ave., Unit 65, Building A-10, Alhambra, CA 91803 ("VENDOR"), with respect to the following facts:

A. CalOptima requires professional VENDOR services to perform Coordination of Benefit (COB) and Overpayment Recovery Services; and

B. VENDOR provides such services; and

C. VENDOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. VENDOR desires to perform these services; and

E. CalOptima and VENDOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE I – DOCUMENTS CONSTITUTING CONTRACT

This Contract shall include, in addition to this document and its exhibits and attachments, VENDOR's proposal, dated November 27, 2007, and the best and final offer, dated February 29, 2008, and all documents cited herein or incorporated by reference. The invalidity in whole or in part of any term or condition of the Contract shall not affect the validity of other terms or

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conditions. CalOptima's failure to insist on any one or more instances upon VENDOR's performance of such terms or conditions of this Contract shall not be construed as a waiver or relinquishment of CalOptima's right to such performance or to future performance of such terms or conditions, and VENDOR's obligation in respect thereto shall continue in full force and effect. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Article III hereof. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the following descending order of precedence: (1) the provisions of this Contract, including all exhibits and attachments; (2) VENDOR's proposal dated November 27, 2007; (3) VENDOR's best and final offer dated February 29, 2008; and (4) all other documents cited herein or incorporated by reference.

ARTICLE II – VENDOR RESPONSIBILITIES

A. STATEMENT OF WORK

1. VENDOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima and the Centers for Medicare and Medicaid Services ("CMS"), the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. VENDOR shall also perform in accordance with its proposal to CalOptima, dated November 27, 2007, and supplemental other information submitted to CalOptima on February 29, 2008.

2. Any conflicts between the requirements of Exhibit A and VENDOR's proposal shall be referred to CalOptima for resolution. All services shall be provided at the times and places designated by CalOptima.

3. VENDOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract.

Name	Function/Title
Christina Dragonetti	Senior Vice President
James Carlouch	Vice President Client Services

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No person named in this Article, or his/her successor approved by CalOptima, shall be removed or replaced by VENDOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

B. INSURANCE

1. During performance hereunder, and entirely at VENDOR's sole expense, VENDOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and VENDOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract.

a. Comprehensive General Liability, including Contractual, Independent Contractors, Products/Completed Operations and Personal Injury Liability; and Automobile Liability, including any autos; with at least the following limits of liability:

i. Primary Bodily Injury Liability limits of $1,000,000 per occurrence; and

ii. Primary Property Damage Liability limits of $1,000,000 per occurrence; or

iii. Combined single limits of liability for Primary Bodily Injury and Primary Property Damage of $2,000,000 per occurrence and in aggregate.

b. Automobile Liability with the following limits of liability:

i. Primary Bodily Injury with limits of $600,000 per occurrence; and

ii. Primary Property Damage with limits of $600,000 per occurrence; or

iii. Combined single limits of liability for Primary Bodily and Primary Property Damage of $1,200,000 per occurrence and in aggregate.

c. Workers' Compensation Insurance within the limits established and required by the State of California.

d. Employer's Liability with limits of $1,000,000

e. Professional Liability with a combined single limit of at least $1,000,000 per occurrence and in aggregate.

2. Prior to commencement of any work hereunder, VENDOR shall furnish to CalOptima's Procurement Department broker-issued certificate(s) of insurance showing the required insurance coverages for VENDOR and further providing that:

a. CalOptima is named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance hereunder; and

b. The coverage shall be primary and noncontributory as to any other insurance with respect to performance hereunder; and

c. Thirty (30) days prior written notice of cancellation be given to CalOptima.

3. "Occurrence," as used herein, means any event or related exposure to conditions which result in bodily injury or property damage.

C. INDEPENDENT CONTRACTOR

VENDOR acknowledges that it is at all times acting as an independent contractor under this Contract and, except as specifically provided herein, not as an agent, employee, or partner of CalOptima. VENDOR agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At VENDOR's expense as described herein, VENDOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of VENDOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). VENDOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

D. ASSIGNMENTS AND SUBCONTRACTING

Except as specifically permitted hereunder, this Contract is not assignable by VENDOR, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract,

assignment is (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in VENDOR (whether in a single transaction or in a series of transactions), (2) the change of more than twenty-five percent (25%) of the directors or trustees of VENDOR (whether in a single transaction or in a series of transactions), (3) the merger, reorganization, or consolidation of VENDOR with another entity with respect to which VENDOR is not the surviving entity, and/or (4) a change in the management of VENDOR from management by persons appointed, elected or otherwise selected by the governing body of VENDOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity. VENDOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

E. NON-EXCLUSIVE RELATIONSHIP

It is understood by the parties that this is a non-exclusive relationship between CalOptima and VENDOR. CalOptima shall have the right to enter into contractual arrangements with one or more vendors who can provide CalOptima with similar or like services.

F. COMPLIANCE WITH APPLICABLE LAW

VENDOR warrants that, in the performance of this Contract, it shall observe and comply with federal, state, and local laws in effect when this Contract is signed or which may come into effect during the term of this Contract.

G. NONDISCRIMINATION CLAUSE COMPLIANCE

During the performance of this Contract, VENDOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. VENDOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. VENDOR and subcontractor(s) shall comply with the provisions of the Fair

Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. VENDOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

VENDOR shall include the nondiscrimination and compliance provisions of Article II.G. in all subcontracts under this Contract.

H. PROHIBITED INTERESTS

VENDOR covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

ARTICLE III – TERM; TERMINATION; CHANGES

A. TERM

This Contract shall commence on May 15, 2008, and shall continue in full force and effect through May 14, 2011, unless earlier terminated, as provided in this Contract. VENDOR shall complete all work in accordance with the project schedule specified in Exhibit A.

B. TERMINATION WITHOUT CAUSE

CalOptima may terminate this Contract at any time by giving VENDOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay VENDOR its allowable cost incurred as of the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima under this Contract.

C. TERMINATION FOR UNAVAILABILITY OF FUNDS

In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

1. CalOptima may terminate this Contract if it does not receive funding from the state of California or the federal government, as applicable, for any fiscal year.

2. In the event of Termination for Unavailability of Funds, as provided in this Article, CalOptima agrees to promptly pay VENDOR all fees and other charges due and payable as of the termination date.

3. In the event of Termination for Unavailability of Funds, as provided in this Article, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify VENDOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

D. TERMINATION FOR DEFAULT

Subject to a ten (10) day cure period, CalOptima may terminate this Contract for VENDOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against VENDOR, or if VENDOR makes an assignment for the benefit of creditors, as defined in Article II, paragraph D., or if VENDOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Article, VENDOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by VENDOR under this Contract.

E. TERMINATION BY VENDOR

1. For Cause. In the event that CalOptima fails to perform any of its duties and obligations under this Agreement or breaches any representations or agreements hereunder and such failure or breach is, in aggregate, such failures or breaches are, material and are not substantially cured within a Cure Period ("Cure Period") defined as ten (10) working days (in the event of non-payment) or sixty (60) working days (in the event that CalOptima does not provide

data files or other information as specified in Exhibit A) after written notice is given to CalOptima specifying the default, VENDOR may, by giving written notice therof to CalOptima, terminate this agreement not less than thirty (30) days from the expiration of the Cure Period.

2. For Convenience. Not sooner than twelve (12) months from the execution date of this Agreement, Vendor may terminate this Agreement in whole or in part without cause, Such termination shall be effected by written notice delivered to CalOptima not less than ninety (90) days prior to the date of termination specified un such notice.

3. Work in Process. For one hundred-eighty (180) days ("Wind-Down Period") from termination of this Agreement for whatever reason, VENDOR shall be permitted to continue providing Services associated with work already in progress. Additionally, VENDOR shall have the right to payment for all associated recoveries received by CalOptima within twelve (12) months of the termination date. CalOptima shall continue to provide assistance reasonably requested by VENDOR related to such activities during the Wind-Down Period. The Wind-Down Period may be extended by mutual written agreement of the parties based on special circumstances.

4. MODIFICATIONS

CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed by a written amendment to the Contract, signed by CalOptima and VENDOR. Execution of amendments shall be contingent upon VENDOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

ARTICLE IV – RECORDS; CONFIDENTIALITY

A. VERIFICATION OF CALOPTIMA COSTS BY GOVERNMENT

Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, VENDOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized

representatives, or the California Department of Health Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of VENDOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. VENDOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information, and, to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. VENDOR further agrees and acknowledges that this provision will be included in any and all agreements with VENDOR'S subcontractors.

B. PAYMENT

CalOptima and VENDOR mutually agree to the payment terms defined in Exhibit B, which is attached hereto and incorporated herein by this reference.

C. CONFIDENTIALITY AGREEMENT

VENDOR agrees to complete a CalOptima Confidentiality Agreement, which is attached hereto as Exhibit C and incorporated herein by this reference. All materials covered under this Confidentiality Agreement shall be designated confidential, to the extent permitted by California law.

D. BUSINESS ASSOCIATE AGREEMENT

VENDOR agrees to sign a Business Associate Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference.

ARTICLE V – MEDICARE ADVANTAGE PROGRAM

A. In addition to compliance with the provisions of Article II.F, above, VENDOR expressly warrants that VENDOR and VENDOR's subcontractors, if any, shall comply with all

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applicable Medicare laws, regulations, and CMS instructions. VENDOR further agrees and acknowledges that this provision will be included in any and all agreements with VENDOR's subcontractors.

B. For any medical records or other health and enrollment information VENDOR maintains with respect to Medicare enrollees, VENDOR shall establish procedures to:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. VENDOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify (a) the purpose or purposes the information will be used within VENDOR's organization; and (b) to whom and for what purpose VENDOR will disclose the information.

2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

C. VENDOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR section 422.257.

D. In addition to the termination provisions of Article III of this Contract, VENDOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that VENDOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay VENDOR its allowable costs incurred to the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima for matters pertaining to this Contract.

E. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, Contractor shall comply with all such requirements at the direction of CalOptima.

F. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of

medical professionals, if any, associated with VENDOR and VENDOR's performance of this Contract.

G. Notwithstanding the delegation by CalOptima to VENDOR the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

H. Notwithstanding the written delegation by CalOptima to VENDOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with VENDOR. With all such delegated activities, CalOptima shall monitor VENDOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

ARTICLE VI – MISCELLANEOUS

A. TIME IS OF THE ESSENCE WITH THIS CONTRACT

B. CalOptima DESIGNEE

The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

C. INDEMNIFICATION

VENDOR shall defend, indemnify and hold harmless CalOptima, its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) for any loss or damages for bodily injuries, including death, or loss of property, or damage to the use of property caused by negligent acts, errors or omissions or willful misconduct by VENDOR, its officers, directors, employees, agents, subcontractors, or suppliers in connection with or arising out of performance of this Contract.

D. OMISSIONS

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter

promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

E. CHOICE OF LAW

This Contract shall be governed by and construed in accordance with the laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in any state court of competent jurisdiction sitting in Orange County, California.

F. FORCE MAJEURE

When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

G. OWNERSHIP OF REPORTS AND DOCUMENTS

The originals of all letters, documents, reports, and other data produced for the purposes of this Contract shall be delivered to, and become the property of CalOptima. Copies may be made for VENDOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima.

H. PATENT AND COPYRIGHT INFRINGEMENT

In lieu of any other warranty by CalOptima or VENDOR against infringement, statutory or otherwise, it is agreed that VENDOR shall defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, or copyright, and shall pay costs and damages finally awarded in any such suit, provided that VENDOR is notified in writing of the suit and given authority, information, and assistance at VENDOR's expense for the defense of

the suit. VENDOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

I. NAMES AND MARKS

Neither party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing, or similar publicly disseminated material without first submitting such material to the other party and obtaining the other party's express written approval of the material and consent to such use.

J. NOTICES

All notices hereunder and communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be effected by delivery of the notices in person or by depositing the notices in the U.S. mail, registered or certified mail, return receipt requested, postage prepaid, and addressed as follows:

To VENDOR:	To CalOptima:
Health Management Systems, Inc.	CalOptima
401 Park Avenue South	1120 West La Veta Avenue
New York, NY 10016	Orange, CA 92868
Attention: Christina Dragonetti	Attention: Mark Finch, C.P.M.
Senior Vice President	Purchasing Manager

K. NOTICE OF LABOR DISPUTES

Whenever VENDOR has knowledge that any actual or potential labor dispute may delay this Contract, VENDOR shall immediately notify and submit all relevant information to CalOptima. VENDOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

L. DISPUTES

This Contract shall be construed and all disputes hereunder be settled in accordance with the laws of the State of California. Pending final resolution of a dispute hereunder, VENDOR shall proceed diligently with the performance of this Contract.

M. NO LIABILITY OF COUNTY OF ORANGE

As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

N. ATTORNEYS FEES

Should either party to this Contract institute any action or proceeding to enforce this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees, incurred by the prevailing party in such arbitration, action or proceeding.

O. ENTIRE AGREEMENT

This Contract contains the entire agreement between VENDOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all other prior contemporary agreements, understandings, and commitments between VENDOR and CalOptima with respect to the subject matter of this Contract.

P. HEADINGS

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

ARTICLE VII – SIGNATURES

This Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Contract No. MC 03193 to be executed on the date first above written.

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HEALTH MANAGEMENT SYSTEMS	CalOptima
By: Christina Dragonetti	By:
Name: Christina Dragonetti	Name: ~~Keith Quinlivan~~ Greg Bucher, MD
Title: Senior Vice President	Title: Chief ~~Financial~~ Operating Officer
Date: 5/19/08	Date: 5/22/08

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SCOPE OF WORK

The following are the services to be performed as the project known as Coordination of Benefit ("COB") and Overpayment Recovery Services. Health Management Systems, Inc. ("HMS") proposes to perform said services on behalf of CalOptima for its Medicaid and Medicare Managed Care member populations ("Program Members"). Expressly excluded from this Agreement are third party lien claims held by the State of California or held for by CalOptima's contracted Providers.

SECTION 1. DATA RECEIPT

1.1 Data Receipt. CalOptima shall provide VENDOR with the following standard data files electronically in a format agreed to by both parties:

1.1.1. Eligibility (monthly)

1.1.2. Known COB/other party resource file (monthly)

1.1.3. Adjudicated Claims/Encounter Data (monthly)

1.1.4. Provider File (monthly)

1.2. Data Programming Fee. A one-time charge of twenty-five cents ($.25) per Program Member will be charged for implementation and initial data programming associated with this project. Fifty (50) per cent of the fees will be billed in equal parts on the date of the Project Kick-Off Meeting and fifty (50) per cent of the fees will be billed on the date the first Billing Cycle is released. This charge shall be based on the number of Program Members as of the date the Agreement is executed by CalOptima.

However, if CalOptima should provide VENDOR with source data from a system or systems different from the core system(s) in use at the time this Agreement is executed, VENDOR will charge a one-time data programming fee of twenty-five thousand dollars

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($25,000) to accommodate CalOptima's data from each additional non-core system it may use.

SECTION 2: INSURANCE BILLING AND PROVIDER RECOUPMENTS

VENDOR will generate complete billings to commercial insurers and TRICARE, and submit such billings to individual carriers, as may be applicable, in connection with patient services paid for by CalOptima but for which a third party is liable.

2.1 Services

2.1.1. Match to Paid Claims/Encounter Data. VENDOR shall match the paid claim/encounter data to VENDOR eligibility database of other third party resources to identify any claims paid by CalOptima to providers that may be the responsibility of another payor.

2.1.2. Perform Recovery. Where direct billing to liable third parties is the most effective recoupment method, VENDOR shall:

2.1.2.1. Bill claims in required format to liable third parties including commercial insurers, Tricare, and Medicare.

2.1.2.2. Receive checks and other remittance documentation in bank lockbox that CalOptima establishes for this project.

2.1.2.3. Where appropriate, rebill and appeal inappropriately denied claims.

2.1.2.4. Supply to CalOptima monthly reports documenting results.

2.1.3. Provider Recoupments. Where recoupment from the provider of service is the effective recoupment method, VENDOR shall:

2.1.3.1 Submit documentation to providers regarding previous payments from CalOptima, as well as coverage information required for the provider to bill the liable third party. All such documentation will be submitted to CalOptima for review and approval prior to being sent to providers.

2.1.3.2. Provide customer service to providers during recoupment period.

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2.1.3.3. Receive checks and other remittance documentation in bank lockbox that CalOptima establishes for the project.

2.1.3.4. Address provider appeals where appropriate.

2.1.3.5 Submit recoupment files to CalOptima at the end of the recoupment period.

2.2 Fees. For the Services within this Scope of Work CalOptima agrees to pay VENDOR the following fees:

2.2.1. Payment of Fees. A contingency fee of Twenty-Five percent (25%) of funds recovered.

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PAYMENT

For VENDOR's full and complete performance of its obligations under this Contract, CalOptima shall pay VENDOR on a contingency fee basis in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

VENDOR may invoice CalOptima on a monthly basis for the Contingency Fee for actual funds recovered. The Contingency Fee, as defined below, is acknowledged to include VENDOR's base labor rates, overhead and profit. Funds recovered shall be documented in a monthly progress report prepared by VENDOR, which report shall accompany each invoice submitted by VENDOR. VENDOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as VENDOR has documented, to CalOptima's satisfaction, that VENDOR has fully completed all work required under this Contract and VENDOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of VENDOR's work under this contract.

Invoices shall be submitted to CalOptima's Accounts Payable Office. Each invoice shall cite Contract No. MC 03193; specify the actual funds recovered; the time period covered by the invoice and the amount of payment requested; and be accompanied by a monthly report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice. No amount shall be invoiced or no amount shall be due or payable by CalOptima prior to receipt by CalOptima of the funds for the recovery or recoupment from Third Party Payors or Providers.

VENDOR's rate shall be a Contingency Fee of Twenty-Five percent (25%) of funds recovered. Additionally, a one time charge of Twenty-five cents ($.25) per member, based on member enrollment as of the date this Agreement is executed by CalOptima, will be charged for implementation and initial data programming associated with this project. This rate is fixed for the duration of the Contract. VENDOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay VENDOR for time spent traveling.

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CONFIDENTIALITY AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Services and CalOptima, HEALTH MANAGEMENT SYSTEMS, INC., including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

HEALTH MANAGEMENT SYSTEMS, INC. further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

HEALTH MANAGEMENT SYSTEMS, INC. further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

HEALTH MANAGEMENT SYSTEMS, INC. further agrees that this Confidentiality Agreement shall remain in full force and effect after the termination of this Contract.

By: Christin Dragonetti Dated: _____

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BUSINESS ASSOCIATE PROTECTED HEALTH INFORMATION DISCLOSURE AGREEMENT

This Business Associate Protected Health Information Disclosure Agreement ("Agreement') is entered into as of May 15, 2008 by and between CalOptima ("Plan") and Health Management Systems, Inc. ("Business Associate").

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 (together, the "Privacy and Security Regulations");

WHEREAS, the Privacy and Security Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Electronic Media" means:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable /transportable electronic storage media. Certain transmissions, including of paper, via facsimile,

and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.3 "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

1.4 "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.5 "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.6 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan. "Protected Health Information" includes Electronic Protected Health Information.

1.7 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

1.8 "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.9 "Services" has the same meaning as in the Services Agreement(s).

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1.10 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.11 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services , and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.2 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

Specifically as to Electronic Protected Health Information, Business Associate warrants that it shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information.

2.3 Reporting Non-Permitted Use or Disclosure and Security Incidents. Business Associate shall report to Plan each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors but is not specifically permitted by this Agreement , as well as each Security Incident of which Business Associate becomes aware. The initial report shall be made by telephone call to Denise Corley, telephone number (714) 246-8594 (Plan's Privacy Officer) within five (5) business days from the time the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident, followed by a full written report to the Privacy Officer no later than twenty (20) business days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident. If Business Associate is unable to provide a full written report within the stated time frames, Business Associate may request an extension of up to ten (10) additional business days. Such requests shall be in written form (facsimile is acceptable), and submitted to Plan's Privacy

Officer within the original twenty (20) business day deadline, and must contain an explanation for the basis of the requested extension. Plan retains the right to approve or deny such requested extensions, however Plan shall not unreasonably deny such requests.

2.4 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5. Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining Plan's compliance with the Privacy and Security Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary and provide Plan with copies of any documents produced in response to such request.

2.6 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.7 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.8 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.8 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

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(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure (but beginning no earlier than April 14, 2003). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

(c) pursuant to a written authorization given by or behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.8 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect. Business Associate's obligations under Sections 2.1 (as modified by Section 4.2), 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 4.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan;

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of the federal Department of Health and Human Services.

3.3 Disposition of Protected Health Information Upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan. This provision shall apply to Protected Health Information that is in

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the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. If return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy and Security Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy and Security Regulations.

EXECUTION

Subject to the execution of the State Contract by CalOptima and the State, this Agreement shall become effective as of May 15, 2008 ("Effective Date").

In witness thereof, the parties have executed this Contract:

Health Management Systems, Inc.	CalOptima
Christina Dragonetti	Mark Finch, C.P.M.
Print Name	Print Name
Christina Dragonetti	
Signature	Signature
Senior Vice President	Purchasing Manager
Title	Title
5/19/08	5.8.2008
Date	Date

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AMENDMENT NO. 1 TO CONTRACT MC 03193

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of the 21st day of April, 2011, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services; and

B. CalOptima and VENDOR agree to delete the key personnel listed within Article II, Section 3 and replace with the following:

Name	Function/Title
Ronald D. Singh	Executive Vice President
James Carlough	Vice President Client Development

C. CalOptima and VENDOR agree to extend the Term of the Contract to May 14, 2014; and

D. CalOptima and VENDOR agree to delete the addressee information within Article VI, Section J and replace with the following:

Health Management Systems, Inc.	CalOptima
401 Park Avenue South	1120 W. La Veta Avenue
New York, NY 10016	Orange, CA 92868
Attention: Ronald D. Singh	Attention: Kathy Hoppe
Executive Vice President	Contract Administrator

E. CalOptima and VENDOR agree to delete Exhibit D, entitled "Business Associate Protected Health Information Disclosure Agreement" dated May 15, 2008 and replace with Attachment A to this Amendment No. 1 entitled "Business Associate Protected Health Information Disclosure Agreement" dated April 21, 2011 which is attached hereto and incorporated herein by this reference; and

F. CalOptima and VENDOR agree to incorporate, and VENDOR agrees to fill out, sign and return to CalOptima, Attachment B, entitled "Offshore Contractors Attestation" which is attached hereto and incorporated herein by this reference; and

G. CalOptima and VENDOR agree that if CalOptima purchases an additional service from VENDOR at any time throughout the duration of this Contract, CalOptima shall receive a three percent (3%) reduction in its rate for the Coordination of Benefit "COB" and Overpayment Recovery Services listed within this Contract.

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SIGNATURES -- This Amendment No. 1 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 1 to the Contract to be executed on the date first above written.

Health Management Systems, Inc. (HMS)

By: _____

Ronald D. Singh
Executive Vice President

CalOptima

By: _____ for

Richard Chambers
Chief Executive Officer

By: _____ for

Michael Engelhard
Chief Financial Officer

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Business Associate Protected Health Information Disclosure Agreement

This Business Associate Protected Health Information Disclosure Agreement ("Agreement") is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima ("Plan"), and Health Management Systems, Inc., ("Business Associate"), on this 21st day of April, 2011.

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, as a Covered Entity, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 (together, the "Privacy and Security Regulations");

WHEREAS, as a Business Associate, VENDOR is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, as required by the HITECH Act, pursuant to Title XIII3 of the American Recovery and Reinvestment Act of 2009;

WHEREAS, the Privacy and Security Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

WHEREAS, the Plan's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to protect Protected Health Information and have required that Plan incorporate such requirements in its subcontracts with subcontractors that require access to the regulator(s)' Protected Health Information;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Electronic Media" means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable /transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

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1.3 "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

1.4 "HHS" means the federal Department of Health and Human Services.

1.5 "HITECH Act" means the Health Information Technology for Economic and Clinical Health (HITECH) Act, codified at 42 U.S.C. §§ 17921–17954.

1.6 "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.7 "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.8 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan. "Protected Health Information" includes Electronic Protected Health Information.

1.9 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

1.10 "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.11 "Services" has the same meaning as in the Services Agreement(s).

1.12 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.13 "Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary of HHS.

1.14 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 HITECH Compliance. Business Associate will comply with the requirements of Title XIII, Subtitle D of the HITECH Act, which are applicable to business associates, and will comply with all regulations issued by HHS to implement these referenced statutes, as of the date by which business associates are required to comply with such

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referenced statutes and HHS regulations. Business Associate is also required to comply with the specific security administrative, physical and technical safeguards identified on Attachment A which is attached hereto and incorporated herein by this reference.

2.2 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services, and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.3 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

Specifically as to Electronic Protected Health Information, Business Associate warrants that it shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information.

2.4 Notification of Breach. During the term of this Agreement:

(a) Discovery of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to notify CalOptima immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form, or any suspected Security Incident, intrusion or unauthorized Use or Disclosure of PHI in violation of this Agreement, or potential or actual loss of confidential data related to the Services Agreement(s). Notification shall be provided to the CalOptima Privacy Officer (CalOptima's Director of Compliance), telephone number (714) 246-8594. Business Associate shall take:

(i) Prompt corrective action to mitigate any risks or damages involved with the breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data and to protect the operating environment. Notwithstanding the foregoing, all corrective actions are subject to the approval of Plan and the Plan's regulator(s).

(ii) Any action pertaining to such breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data required by applicable Federal and State laws and regulations.

(iii) Any additional corrective actions required by Plan or Plan's regulator(s).

(b) Investigation of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to immediately investigate such Security Incident, breach, or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data. Within three (3) working days of the discovery, Business Associate shall notify the CalOptima Privacy Officer of matters described below:

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(i) The nature of the data elements involved and the extent of the data involved in the breach,

(ii) A description of the unauthorized persons known or reasonably believed to have improperly Used or Disclosed PHI or confidential data,

(iii) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,

(iv) A description of the probable causes of the improper Use or Disclosure;

(v) Whether the PHI or confidential data that is the subject of the Security Incident, breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured Protected Health Information;

(vi) Whether a law enforcement official has requested a delay in notification of individuals of the Security Incident, breach, or unauthorized Use or Disclosure of PHI or confidential data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

(vii) Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications of breaches are triggered.

(c) Written Report. Business Associate shall provide a comprehensive written report to Plan no later than ten (10) working days after discovery of the Security Incident, breach, or other unauthorized Use or Disclosure of PHI or confidential data, providing a comprehensive discussion of the above matters identified in section 2.3(b) above and the following matters:

(i) The potential impacts of the incident, e.g. potential misuse of data, identity theft, etc;

(ii) The steps taken in mitigation to reduce the harmful effects of the breach, as required by Section 2.4; and

(iii) A corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future. Notwithstanding the foregoing, all corrective actions are subject to the approval of Plan and the Plan's regulator(s).

2.5 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.6 Notification of Breach to Individuals. Business Associate shall comply with federal and state laws requiring notice to individuals of breaches of PHI or confidential data including, without limitation, Section 13402 of the HITECH Act, codified at 42 U.S.C. § 17932. Business Associate shall comply with all regulations issued by HHS to implement Section 13402, as of the date by which business associates are required to comply with such referenced statutes and HHS regulations. All such notifications to affected individuals shall be coordinated with Plan and Plan shall approve the time, manner, content and method for notice to individuals including, without limitation, requiring Business Associate to directly send and pay for such notices at Plan's discretion. Business Associate will immediately indemnify and pay Plan for (i) any and all fees and expenses Plan incurs in investigating, responding to, and/or mitigating a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys fees, costs, liabilities or other sums actually incurred by Plan due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or penalties assessed or imposed against Plan by any government agency/regulator based on a breach of PHI or confidential data caused by Business Associate or

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its subcontractors or agents. Such fees and expenses may include, without limitation, attorneys fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges.

2.7 Employee Training and Discipline. Business Associate agrees to train and use reasonable measures to ensure compliance with the requirements of this Agreement by employees, volunteers and, if permitted, subcontractors who assist in the performance of functions or activities under this Agreement and Use or Disclose PHI. Business Associate agrees to discipline such employees, volunteers and subcontractors who intentionally violate any provisions of this Agreement, including by termination of employment or subcontract.

2.8 Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of HHS for purposes of determining Plan's compliance with the Privacy and Security Regulations. . Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Plan and the Secretary of HHS for purposes of determining Business Associate's compliance with the applicable Privacy and Security Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary of HHS and provide Plan with copies of any documents produced in response to such request.

2.9 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.10 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.11 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.11 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.11, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure (but beginning no earlier than April 14, 2003). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

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(c) pursuant to a written authorization given by or on behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.11 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

2.12 Audits, Inspection and Enforcement. From time to time, Plan may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any provision of this Agreement and shall certify the same to the Plan in writing. The fact that Plan inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor do the following constitute acceptance of Plan's:

(a) Failure to detect or

(b) Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitutes acceptance of such practice or a waiver of CalOptima's enforcement rights under this Agreement.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect. Business Associate's obligations under Sections 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12 and 3.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan; or

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of HHS.

3.3 Disposition of Protected Health Information upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan in accordance with data destruction methods specified in Attachment A to this Agreement. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. Subject to the approval of Plan's regulator(s) if necessary, if return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

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MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy and Security Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy and Security Regulations.

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Attachment A

Business Associate Data Security Requirements
Subcontractors with Access to DHCS Data and PHI

DEFINITIONS

A. "DHCS Data" means for purposes of this Attachment A, all information provided by DHCS to the Plan which is accessed by Business Associate under the Services Agreement.

B. "DHCS PHI" means for purposes of this Attachment A, Protected Health Information and a subset of DHCS Data.

C. "Approved Technical Encryption Solution" means an industry recognized encryption solution or an encryption solution approved by CalOptima's regulator(s).

I. GENERAL SECURITY CONTROLS

1.1 Confidentiality Statement. All persons that will be working with DHCS PHI must sign an annual confidentiality statement prior to access to DHCS PHI. Business Associate shall retain each person's written confidentiality statement for CalOptima inspection for a period of three (3) years following contract termination.

1.2 Background check. Before a member of the Business Associate's workforce may access DHCS PHI, Business Associate must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data. The Business Associate shall retain each workforce member's background check documentation for CalOptima inspection for a period of three (3) years following contract termination.

1.3 Workstation/Laptop encryption. All workstations and laptops that process and/or store Protected Health Information must be encrypted with an Approved Technical Encryption Solution.

1.4 Minimum Necessary. Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for current business purposes.

1.5 Removable media devices. All electronic files that contain DHCS PHI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with an Approved Technical Encryption Solution

1.6 Email security. All emails that include DHCS PHI must be sent in an encrypted method using an Approved Technical Encryption Solution.

1.7 Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

1.8 Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI must have security patches applied and up-to-date.

1.9 User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared, must be at least eight characters, be a non-dictionary word, stored in readable format on the computer, changed every 60 days, and changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

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1.10 Data Destruction. All PHI must be wiped from systems when the data is no longer necessary. The wipe method must conform to Department of Defense standards for data destruction (known as DoD 5220.22-M) or other solution approved in advance by CalOptima's regulator(s). All paper containing DHCS data must be shredded. Once data has been destroyed, CalOptima must be notified.

1.11 Remote Access. Any remote access to DHCS PHI must be executed over an Approved Technical Encryption Solution. All remote access must be limited to minimum necessary and least privilege principles.

II. SYSTEM SECURITY CONTROLS

2.1 System Timeout. The system must provide an automatic timeout after no more than 20 minutes of inactivity.

2.2 Warning Banners. All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users must be directed to log off the system if they do not agree with these requirements.

2.3 System Logging. The system must log success and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing DHCS PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.

2.4 Access Controls. The system must use role based access controls for all user authentications, enforcing the principle of least privilege.

2.5 Transmission encryption. All data transmissions must be encrypted end-to-end using an Approved Technical Encryption Solution when transmitting PHI such as solutions using 128bit SSL, FTPS or SFTP.

III. AUDIT CONTROLS

3.1 System Security Review. All systems processing and/or storing DHCS PHI must have at least an annual system security review. Reviews must include administrative and technical vulnerability scanning tools.

3.2 Log Reviews. All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access.

3.3 Change Control. All systems processing and/or storing DHCS PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. BUSINESS CONTINUITY / DISASTER RECOVERY CONTROLS

4.1 Emergency Mode Operation Plan. Business Associate must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under the Services Agreement(s) for more than 24 hours.

4.2 Data Backup Plan. Business Associate must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI. The plan must include a regular schedule for making backups, storing backup's offsite, an inventory of backup media, and the amount of time to restore DHCS PHI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of CalOptima data.

V. PAPER DOCUMENT CONTROLS

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5.1 Supervision of Data. DHCS PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

5.2 Escorting Visitors. Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area.

5.3 Confidential Destruction. DHCS PHI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

5.4 Removal of Data. If CalOptima provides Business Associate with access to DHCS PHI to perform services off-site (i.e. not at CalOptima's business premises), Business Associate shall not remove DHCS PHI to any overseas or offshore location. In the event that Business Associate is permitted to deliver DHCS PHI to any party as part of its obligations under the Services Agreement(s), then Business Associate shall comply with all safeguard requirements related to the transmission and/or delivery of DHCS PHI set forth in this Attachment.

5.5 Faxing. Faxes containing DHCS PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

5.6 Mailing. DHCS PHI shall only be mailed using secure methods. Large volume mailings of PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted with an Approved Technical Encryption Solution.

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CalOptima
A Public Agency
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MC 03193
Amendment No. 1
Attachment B

Offshore Contractors Attestation

Check which CalOptima line/s of business this form pertains to:

√ OneCare
√ Medi-Cal
√ Healthy Families

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? ("X" where appropriate)

No [X] if no, please complete Part I and return the document with Amendment No. 1 to khoppe@caloptima.org.

Yes [ ] if yes, please complete Parts II – VI of this form and return the document with Amendment No. 1 to khoppe@caloptima.org.

Part I – Our Firm is Not Using Offshore Subcontractors

Name of Organization:	HEALTH MANAGEMENT SYSTEMS
Federal Tax I.D. No:	13-2770433
Name of Authorized Person:	SANDRA MCMANUS
Title:	SR. OPERATIONS DIRECTOR
Signature:	
Date:	5/6/11

Part II – Offshore Subcontractor Information

Subcontractor Name:	
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: _____

Part III – Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor:

2. Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives:

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:

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CalOptima
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MC 03193
Amendment No. 1
Attachment B

Part IV – Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medi-Cal beneficiary protected health information (PHI) and other personal information remains secure.	
B.	Offshore subcontracting arrangement prohibits subcontractor's access to Medi-Cal data not associated with CalOptima's contract with the offshore subcontractor.	
C.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	
D.	Offshore subcontracting arrangement includes all required DHCS language as stipulated within your contract with CalOptima.	

Part V – Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore subcontractor.	
B.	Audit result will be used by your organization to evaluate the continuation of its relationship with the Offshore subcontractor.	
C.	Your organization agrees to share Offshore subcontractor's audit results with CalOptima, upon request.	

Part VI – Organization Information

Name of Organization:	
Federal Tax I.D. No:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

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AMENDMENT NO. 2 TO CONTRACT MC 03193

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of the May 15, 2014, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and VENDOR desire to extend the Contract Term.

C. CalOptima and VENDOR desire to reduce the Contingency Percentage Fee for COB and Overpayment Recovery Services for Medi-Cal and Rx.

D. CalOptima requires VENDOR to provide updated Offshore Contractors Attestation information.

E. CalOptima and VENDOR entered into Amendment No. 1 to this Contract on April 21, 2011.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the Term of the Contract to May 14, 2017, after which the contract shall automatically terminate unless renewed via written Amendment signed by both parties. within thirty (30) days of the expiration date of the current term. .

2. Amend the Original Contract Exhibit B, paragraph 4, first sentence in its entirety and replace with "VENDOR's rate shall be a Contingency Fee of Twenty-Three percent (23%)".

3. VENDOR shall complete, sign and return Attachment No. 1 to this Amendment No. 2, entitled "Offshore Contractors Attestation" which is attached hereto and incorporated herein by this reference.

4. The flowchart attached hereto as Attachment No. 2 to this Amendment No. 2 is being added to help all parties understand the flow of data between each party and includes guidelines on what collections can be made by VENDOR.

5. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite "Contract MC 03193, Amendment No. 2.

6. All other terms and conditions listed within the Contract not affected by this Amendment No. 2 shall remain in full force and effect.

7. SIGNATURES – This Amendment No. 2 to the Contract shall be made effective upon execution by both parties.

[Remainder of Page Left Intentionally Blank]

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IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 2 to the Contract to be executed on the date first above written.

Health Management Systems, Inc. (HMS)
By: H. Brent Sanders

Ronald D. Singh
Executive Vice President

H. Brent Sanders
Vice President, Commercial sales

CalOptima
By:

Chet Uma
Chief Financial Officer

By:

Michael Schrader
Chief Executive Officer

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Offshore Contractors Attestation

Check which CalOptima line/s of business this form pertains to:

- √ OneCare
- √ Medi-Cal
- √ Healthy Families

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? ("X" where appropriate)

No ☐ If no, please complete Part I and return the document as part of Amendment No. 2.

Yes ☒ If yes, please complete Parts II through VI of this form and return the document as part of Amendment No. 2.

Part I – Our Firm is Not Using Offshore Subcontractors

Name of Organization:	
Federal Tax I.D. No:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

Part II –Offshore Subcontractor Information

Subcontractor Name:	***See Attached List***
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: _____

Part III –Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor:
There is remittance that is available to the employee, but data RESIDES in the US.

2. Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives:
PHI is at the heart of what HMS does (Coordination of Benefits)

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:
The data is critically necessary for each function, so there is no way to avoid it.

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Part IV – Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medi-Cal beneficiary protected health information (PHI) and other personal information remains secure.	Yes
B.	Offshore subcontracting arrangement prohibits subcontractor's access to Medi-Cal data not associated with CalOptima's contract with the offshore subcontractor.	Yes
C.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	Yes
D.	Offshore subcontracting arrangement includes all required DHCS language as stipulated within your contract with CalOptima.	Yes

Part V – Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore subcontractor.	Yes
B.	Audit result will be used by your organization to evaluate the continuation of its relationship with the Offshore subcontractor.	Yes
C.	Your organization agrees to share Offshore subcontractor's audit results with CalOptima, upon request.	Yes

Part VI – Organization Information

Name of Organization:	Health Management Systems, Inc.
Federal Tax I.D. No:	
Name of Authorized Person:	Beau Fidler
Title:	VP Account Management
Signature:	
Date:	3/4/15

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HMS Off-Shore Contractors

Subcontractor Name:	HOVG
Subcontractor Country:	USA
Subcontractor Address:	1901 W. 10th Street - Antioch, CA 94509 - 925-757-4533
Describe Offsore Subcontractor Functions:	
Claims Recovery	

Subcontractor Name:	MiraMed
Subcontractor Country:	Chennai, India
Subcontractor Address:	Donna.perry@ajubanet.net - 877-702-5822 - ext 6502
Describe Offsore Subcontractor Functions:	
Claims Recovery	

Subcontractor Name:	Datamatics
Subcontractor Country:	Chennai, India
Subcontractor Address:	Sunil_dixit@datamaticstech.com - 734-525-5228
Describe Offsore Subcontractor Functions:	
Health Plan Verifications	

Subcontractor Name:	Source HOV
Subcontractor Country:	Chennai, India
Subcontractor Address:	Ramith.anthony@hovservices.com
Describe Offsore Subcontractor Functions:	
Keypunch & Lockbox Imaging	

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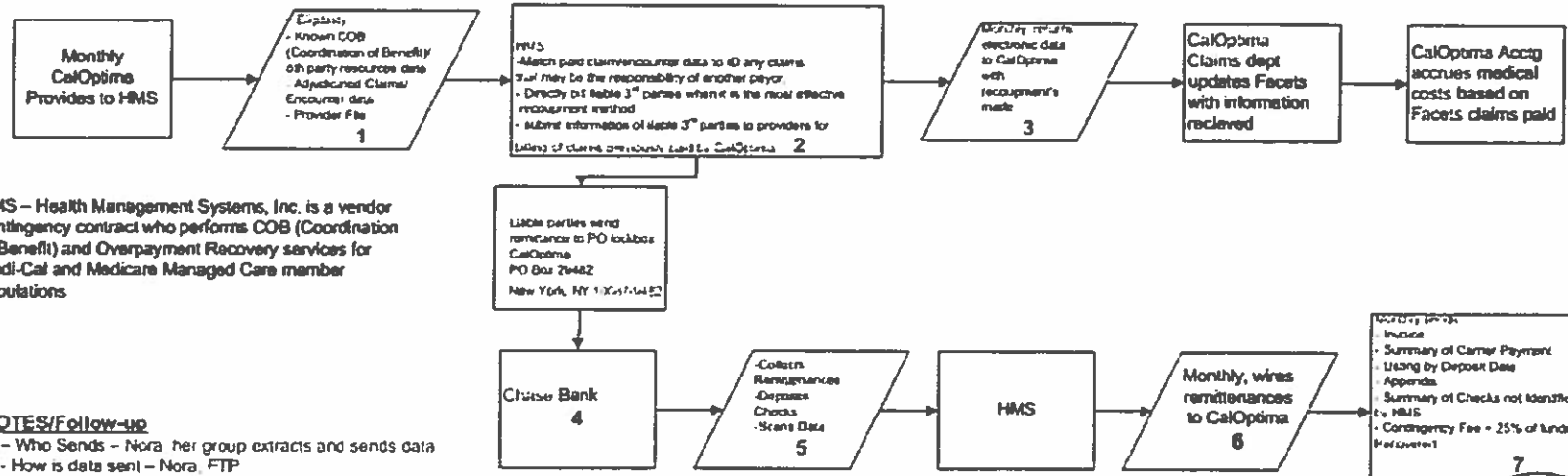
HMS – Health Management Systems, Inc., Interaction Flow



HMS – Health Management Systems, Inc. is a vendor contingency contract who performs COB (Coordination of Benefit) and Overpayment Recovery services for Medi-Cal and Medicare Managed Care member populations

NOTES/Follow-up

1. – Who Sends – Nora her group extracts and sends data
   - How is data sent – Nora, FTP
   - When/Frequency of sending – Nora, Monthly. Alberta only new claims (latest info) is sent
   - What other data is passed – Nora, None
2. – Not verified with vendor (HMS) Verified with HMS
3. – Who receives – Nora, received from HMS via FTP Posted to G Drive for Claims review
   Alberta, lately, returns have been sporadic
   - How is this received? – See above
   - What is done with data? – See above Alberta her team does the review If other insurances are discovered, identified changes are passed to Member Services for COB update (in FACETS) This is then updated to the State System (sent to SSA) via forms State sends data back to update CalOptima data
   - Are these booked to the member? Nora, not by IS
4. – HMS set-up lock box with Chase under CalOptima name. Who has access? This serves as a central repository Carriers can send payment to this PO Box HMS only has read only access and will log in for reconciliation purposes (monies that are received and EOBs)! HMS will provide list of authorized users
   - Do we have a BAA with Chase? HMS will send a copy
5. – Not verified
6. - Who reconciles remittenances? Monthly Chase will initiate wire transfer all monies collected Budget has reconciled
   Invoices received to monthly remittenances for Calendar 2014. We have no evidence that this was performed in the past.
   - How are payments booked to member (how are claims adjusted to member)?
   - What back-up data is received and to who?
7. – Invoices are addressed to Marsha Buford. Is there addt'l info sent to CalOptima?
   Match wire transfer to? – Alberta Marsha was previous Claims Director Michelle Hoban validates the monthly report to ensure the Claims are in our system There is no detailed review of the data Note an additional sheet with member data is received (Ken-we have not reviewed this sheet. We have not reviewed the validation procedures). Alberta EOB comes from the carrier EOB should (835's electronic remit) comes with the payment
8. – Source: HMS
9. – As stated by the Director. This has not been verified

Note: HMS will only follow-up on items going back 3 years from date of service. Most collections are made within the first 90 days. 120 days and greater less of collection chance. It is in HMS best interest to track down the EOB from the carrier. **When asked how CalOptima could have received a collection for a non-CalOptima member**, HMS replied that it could happen via human error. Collection sent to the wrong lock box

Legend:
Nora Onishi, 12-5-14
Alberta Forester, 12-8-14
HMS 12-16-14
Budget

Follow-up, 2-13-15:

- *On-going maintenance to reconcile HMS invoice to funds received via Wire Transfer – Accounting*
- *Reconcile received HMS FTP file to our membership - Claims*
- *Link Claims received to member file (for RDT purposes) – Claims & IS*
- *Review HMS processes to ensure 1. Contract terms are enforce and, 2. Scenarios which occurred are addressed in HMS workflow. - Finance*

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AMENDMENT NO. 3 TO CONTRACT MC 03193
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA
AND
HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 3 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and Vendor entered into Amendment No. 1 on April 21, 2011 and Amendment No. 2 on May 15th, 2014.

C. CalOptima and VENDOR desire to extend the Contract Term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the Contract to May 14th, 2020.

2. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite Contract MC 03193, Amendment No. 3.

3. All other terms and conditions listed within the Contract and previous two Amendments not affected by this Amendment No. 3 shall remain in full force and effect.

4. SIGNATURES – This Amendment No. 3 to the Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 3 to the Contract to be executed on the date last executed below.

Health Management Systems, Inc. (HMS)

Name: Richard Fidler

Signature: _____

Title: VP, Health Plan Solutions

Date: 4/5/17

CalOptima

Name: Nancy Huang

Signature: _____

Title: Int. CFO & treasurer

Date: 4-7-17

Name: Michael Schrader

Signature: _____

Title: CEO

Date: 4-10-17

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AMENDMENT NO. 4 TO CONTRACT MC 03193
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA
AND
HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 4 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and Vendor entered into Amendment No. 1 on April 21, 2011, Amendment No. 2 on May 15th, 2014, and Amendment No. 3 on April 10, 2017.

C. CalOptima and VENDOR desire to extend the Contract Term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the Contract to May 14th, 2023.

2. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite Contract MC 03193, Amendment No. 4.

3. All other terms and conditions listed within the Contract and previous three Amendments not affected by this Amendment No. 4 shall remain in full force and effect.

4. SIGNATURES – This Amendment No. 4 to the Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 4 to the Contract to be executed on the date last executed below.

Health Management Systems, Inc. (HMS)

Name: Maria Perrin

Signature: DocuSigned by: Maria Perrin C7CE114128A349B...

Title: EVP, Chief Growth Officer

Date: 4/23/2020

CalOptima

Name: Nancy Huang

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Title: CFO, CalOptima

Date: 04/27/2020

Name: Richard Sanchez

Signature: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...

Title: Interim CEO, CalOptima

Date: 04/27/2020

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May 13, 2021

VIA FEDEX

CalOptima
1120 W. La Veta Ave.
Orange, CA 92868
Attn: Mark Finch, C.P.M., Purchasing Manager

Dear Mr. Finch:

We are writing in follow up to our March 31, 2021 notice regarding the pending acquisition of HMS Holdings Corp. (together with its subsidiaries, "HMS") by Gainwell Acquisition Corp. ("Gainwell"). We are pleased to inform you that the transaction has now closed, resulting in a change of control for HMS.

As a Gainwell Technologies Company, HMS will continue with its Medicaid, Managed Care and Medicare Advantage coordination of benefits operations, and Cotiviti, Inc. ("Cotiviti") acquired the HMS capabilities focused on population health management, payment integrity for the commercial, Medicare and Medicaid markets and coordination of benefits for the commercial markets (collectively, the "Transaction"). The Transaction does not have any impact on your agreements with HMS (collectively, the "Agreements"), as the contracting entity remains Health Management Systems, Inc. and the payment information remains the same. The combination of Gainwell and HMS will enable us to bring new innovative technologies and solutions to you and help you deliver great health and human services outcomes in the communities we both serve.

In further fulling our contractual obligations, we respectfully request that you return a signed copy of this letter to us by email at legal@hms.com by May 31, 2021, which will constitute your acknowledgment and agreement, that any notice or consent requirements related to the Transaction under the Agreements have been fulfilled and that you waive any termination rights that you may have with respect to the Transaction. A digital or scanned and emailed signature will be deemed an original signature. If you would like to discuss this matter further, please contact your HMS account manager. We are excited about the opportunities this transaction will offer and appreciate your prompt attention to this matter.

Sincerely,

Maria Perrin
Chief Growth Officer

Acknowledged and Agreed to as of this ____ day of _____ 2021:

By: _____
Name:_____
Title:_____

Emdeon Payer Agreement

Customer #: _____
File #: _____
Contract ID: MC 04123

This agreement ("Agreement") is entered into between the Payer identified below ("Payer") and Envoy LLC, an Emdeon company ("Emdeon"). This Agreement governs the use of the Emdeon Services selected below. This Agreement includes the General Terms and Conditions set forth below as well as the Terms and Conditions contained in the selected Emdeon Services Schedule(s) (individually, a "Service Schedule" and collectively, the "Service Schedules").

SECTION 1 - PAYER ADDRESSES AND CONTACT INFORMATION.

Payer Information		**Billing Information** (for Invoices)	
Payer Tax ID 33-0599891		X *Same as Payer*	
Payer Name **ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA**		Payer Name	
Primary Contact Mark Finch, C.P.M., CPPO	Email address: mfinch@caloptima.org	Primary Contact Linda Rodriguez	email address: lrodriguez@caloptima.org
Address 1120 West La Veta Avenue		Address Same	
City Orange		City Same	
State CA	Zip 92868	State Same	Zip Same
Telephone 714-246-8660	Fax	Telephone 714-246-8566	Fax

SECTION 2 - SELECTION OF EMDEON SERVICES.

X Emdeon E-Services (Governed by the additional Terms and Conditions outlined on **Emdeon E-Services Schedule**)

SECTION 3 - GENERAL TERMS AND CONDITIONS.

A. Fees.

1. Payment Terms. Payer shall pay all fees and expenses outlined in the applicable Services Schedule(s). Payments for all fees and expenses are due in full within thirty (30) days from the original invoice date, and all payments shall be made in U.S. dollars. Payer agrees to pay a late charge of one and one-half percent (1.5%) per month or the maximum lawful rate, whichever is less, for all amounts that remain due and payable by Payer to Emdeon for more than thirty (30) days. In the event Payer has a good faith dispute related to an invoiced amount, Payer shall notify Emdeon within ten (10) days of receipt of the disputed invoice. Payer shall pay the remaining balance of the undisputed invoiced amount in accordance with this section. Both parties shall work diligently and in good faith to resolve any disputed invoice amounts within thirty (30) days of notice of a dispute. Any invoice issued under this Agreement that is not disputed in good faith by Payer within ninety (90) days of such invoice's original date shall be deemed accepted by Payer and Payer agrees to waive any and all claims related thereto.

2. Taxes. Payer shall be responsible for and pay all federal, state, and local taxes or other levies ("Taxes") that are imposed, designated, levied, or based upon the services and products provided for herein, excluding those taxes based on net income derived by Emdeon. Payer shall indemnify and hold Emdeon harmless from all claims and liability resulting from Payer's failure to pay such amounts. All fees set forth in any Services Schedule are quoted exclusive of all Taxes.

B. Term.

1. Term of Agreement. This Agreement shall commence on the Effective Date and shall remain in effect so long as any Services Schedule is in effect and has neither expired nor been terminated.

2. Termination.

a. Either party may terminate this Agreement and any Services Schedule: (i) if the other party fails to perform its material obligations under this Agreement, and such failure is not corrected within thirty (30) days after receipt of written notice of the same, except in the case of failure to pay fees, which must be cured within ten (10) days after receipt of notice from Emdeon; or (ii) if a trustee is appointed to either party for the benefit of creditors, or either party becomes insolvent, bankrupt or initiates a voluntary dissolution; or (iii) as provided for within each Services Schedule. If Payer fails to make payments to Emdeon in accordance with this Agreement, such failure shall be considered substantial nonperformance and cause for termination or, at Emdeon's option, cause for suspension of all services in accordance with Section 3.B.3. below.

b. Termination for Unavailability of Funds -- In recognition that Payer is a governmental entity and its operations and budgets are determined on an annual basis, Payer shall have the right to terminate this agreement, contract, or purchase order if it does not receive funding from the State of California for any fiscal year. Payer agrees to promptly pay Emdeon all fees and other charges due and payable as of the termination date. In the event of Termination for Unavailability of Funds, and funds are received by Payer from the State of California within one-hundred twenty (120) days of the date of termination, then Payer shall promptly notify Emdeon in writing and Payer shall have the right to reinstate this Agreement, contract or purchase order for that period for which funds are received by Payer or the unexpired term of this Agreement, contract or purchase order as of the date of termination, whichever period is shorter in duration, and Payer shall pay all sums due prior to such termination and any expenses incurred in the interruption and resumption of services. Notwithstanding the foregoing, Payer may only reinstate this Agreement, contract or purchase order two (2) times during its term.

3. Suspension. If Emdeon elects to suspend services pursuant to Section 3.B.2., Emdeon shall give Payer ten (10) days prior notice (unless Emdeon deems immediate suspension necessary to prevent harm to Emdeon or its business) and Emdeon shall have no liability to Payer for delay or damage caused Payer by such suspension. Before resuming services, Emdeon shall be paid all sums due prior to suspension and any expenses incurred in the interruption and resumption of the services. If services are suspended, Emdeon reserves the right to terminate this Agreement in accordance with the last sentence of Section 3.B.2., at any time by giving not less than five (5) days prior written notice.

4. Effect of Termination. Upon termination of this Agreement for any reason, all rights granted to Payer hereunder shall terminate, and Payer shall immediately discontinue use of all products and services authorized under this Agreement and the Service Schedule(s) (the "Emdeon Products and Services") and pay all outstanding amounts due to Emdeon hereunder. In addition, Payer shall promptly return all data, drawings, diagrams, designs, documents, software, specifications, input formats, manuals, hardware and materials supplied by Emdeon to Payer ("Emdeon Materials"). In such event, Payer shall certify in writing to Emdeon that every and all such Emdeon Materials in Payer's possession have been returned to Emdeon. In the event of any termination or expiration of this Agreement, Sections 3.B.4., 3.C, 3.D, 3.F, 3.G and 3.H of the General Terms and Conditions shall survive such termination and continue in effect.

C. Confidentiality.

1. Definition. For purposes of this Agreement, "Confidential Information" shall mean any data or information disclosed by one party to the other in connection with this Agreement that is not generally known to the public, and is clearly identified as confidential or, by its nature, should reasonably be considered confidential, including, but not limited to: (a) the terms and conditions of this Agreement (excluding the existence of this Agreement); (b) information about product plans, marketing strategies, finance, operations, customer relationships, customer profiles, customer lists, sales estimates or financial performance of either party; (c) any computer software or computer database (including the software, embedded software, documentation or any portion thereof), including the source code or object code thereof, and any specifications, data, reports, formulae, data models, data formats, field or record layouts, or improvements related thereto; and (d) any individually identifiable medical or financial information. Confidential Information shall not include information that: (v) is or becomes a part of the public domain through no fault of the receiving party; (w) was lawfully received by the receiving party from a third party free of any obligation of confidence; (x) was already in the lawful possession of the receiving party prior to receipt from the disclosing party; or (y) the receiving party can show by a preponderance of documentary evidence was subsequently and independently developed by its employees, consultants or agents without reference to the Confidential Information of the disclosing party; or (z) is disclosed as a result of a request under the California Public Records Act per California Government Code Section 6250 et seq.

2. Confidentiality Obligations. Each party acknowledges that the Confidential Information of the other party is proprietary and confidential and may contain valuable trade secrets. Each party shall hold the Confidential Information of the other in confidence and protect the same with at least the same degree of care with which it protects its own most sensitive confidential information, but in any event no less than reasonable care. Each party shall use the Confidential Information of the other solely in connection with the exercise of its rights, and the performance of its obligations, under this Agreement and shall restrict disclosure of and access to the Confidential Information of the other party to its employees who require access to such Confidential Information in connection with this Agreement. Each party shall require its employees to comply with the obligations of confidentiality set forth herein and shall be liable for any employee's failure to so comply. If a receiving party is required by judicial, administrative or other governmental order to disclose any Confidential Information of the other party, it shall notify the other party prior to making any such legally required disclosure in a timely manner and provide reasonable cooperation in order to allow such party to seek a protective order or other appropriate remedy. Provided such notification is given, the receiving party is hereby authorized to comply with such judicial, administrative or governmental order.

3. Ownership. All Confidential Information shall remain the property of the disclosing party providing the Confidential Information. Nothing in this Agreement is intended to grant any rights in or to the Confidential Information of the other party except as expressly set forth herein. All Confidential Information shall be returned to the disclosing party upon written request or termination of this Agreement.

4. Equitable Relief. Except for either party's compliance with Section 3.H.17. of this Agreement, in the event of a breach by a party of Sections 3.C.2. or 3.C.3., the non-breaching party may not have an adequate remedy solely in money damages and any such breach will cause the non-breaching party irreparable harm. In the event of such breach, the non-breaching party may seek, without the requirement of posting a bond or other security, equitable relief, including an injunction or specific performance.

D. Proprietary Information.

1. Proprietary Rights. With the exception of the limited use rights expressly granted in this Agreement, Emdeon (on behalf of itself and its third party licensors) reserves any and all right, ownership, title, and interest in the Emdeon Products and Services and the Emdeon Materials (collectively, the "Emdeon IP"), and Payer shall treat the Emdeon IP as the property of Emdeon. This Agreement does not effect any transfer of title in any Emdeon IP. Payer acknowledges and agrees that the Emdeon IP, and all intellectual property rights (including, without

limitation, copyright, patent, trade secrets, confidential information rights, and moral rights) derived or devolving from the Emdeon IP, and all derivative works of the Emdeon IP, and such intellectual property rights (including, without limitation, data compilations, abstracts, aggregations and statistical summaries), and all information regarding the foregoing (including but not limited to technology and know-how information) and all copies of the foregoing, regardless of by whom prepared, are owned by and are valuable, special and unique assets of Emdeon and may be provided to third parties by Emdeon and its affiliates consistent with law. Payer further expressly acknowledges and agrees that the foregoing are the confidential property and trade secrets of Emdeon and "Confidential Information" of Emdeon subject to Section 3.C above, whether or not any portion thereof is or may be validly trademarked, copyrighted or patented.

2. Restrictions. Payer will make no attempt to ascertain the circuit diagrams, source code, schematics, logic diagrams, components, operation of, or otherwise attempt to decompile or reverse engineer, any portion of the Emdeon IP. Except as specifically authorized by Emdeon in writing, Payer may not copy any portion of the Emdeon IP, or modify or transfer the Emdeon IP, or any copy or merged portion thereof, in whole or in part, or prepare any derivative works of the Emdeon IP. To the extent that Payer or its employees or contractors conceive, reduce to practice, develop or otherwise participate in the creation or development of technology related to the Emdeon IP, including any derivatives, improvements, enhancements or extensions of such technology, Payer, on behalf of itself and its employees and contractors, hereby assigns to Emdeon all right, title and interest, including (without limitation) all intellectual property rights, therein. Payer shall cooperate with Emdeon in any claim or litigation against third parties that Emdeon may determine to be appropriate to enforce its property rights respecting Emdeon IP. The breach or threatened breach by Payer of any provision of this Section 3.D will subject Payer, at Emdeon's option, to the immediate termination of all Payer's rights hereunder, and Emdeon shall be entitled to an injunction restraining such breach without limiting Emdeon's other remedies for such breach or threatened breach, including recovery of damages from Payer.

E. Indemnification.

1. Indemnification by Emdeon. Emdeon agrees to indemnify, defend and hold Payer harmless from and against any loss, claim, judgment, liability, damage, action or cause of action (including reasonable attorneys' fees and court costs) (collectively, "Losses") directly resulting from a third party claim that Payer's proper use of the Emdeon IP infringes or misappropriates a valid U.S. patent or copyright issued or registered prior to the Effective Date; provided, however, that Emdeon shall have no obligation to indemnify, defend or hold Payer harmless with respect to such third party claims unless Payer promptly notifies Emdeon in writing of the claim, allows Emdeon to exclusively control the defense of such claim, and cooperates reasonably with Emdeon in the defense of the claim or in any related settlement negotiations.

2. Limitation on Indemnification Obligations. The indemnity against infringement set forth in Section 3.E.1. shall not apply to any claim arising out of: (a) the combination, operation or use of the Emdeon IP with any product, data or apparatus not furnished by or on behalf of Emdeon or not specified by Emdeon in writing (b) Emdeon's compliance with Payer's designs, specifications or instructions, (c) Payer's modification of the Emdeon IP, (d) use of the Emdeon IP in a manner that conflicts with the prescribed uses in the applicable specifications, (e) use of the Emdeon IP other than in accordance with this Agreement, or (f) use of other than a current release of any Emdeon software.

3. Quiet Enjoyment of the Emdeon IP. If an infringement claim has been brought, or Emdeon believes such an infringement claim is reasonably likely, Emdeon may, at its sole option and expense: (a) use commercially reasonable efforts to procure the right to continue using the infringing Emdeon IP; (b) replace or modify the same so that it becomes non-infringing; or (c) terminate this Agreement. If this Agreement is so terminated, Emdeon shall refund to Payer all amounts paid by Payer for the applicable Emdeon IP during the one year preceding Emdeon's refund. THIS SECTION 3.E STATES EMDEON'S ENTIRE LIABILITY TO PAYER WITH RESPECT TO ANY INTELLECTUAL PROPERTY INFRINGEMENT CLAIMS BROUGHT BY ANY THIRD PARTY AND SUCH LIABILITY IS FURTHER LIMITED BY THE LIMITATIONS APPEARING IN SECTIONS 3.F AND 3.G BELOW. THERE IS NO WARRANTY WITH RESPECT TO PAYER'S QUIET ENJOYMENT OF THE EMDEON IP OR AGAINST INFRINGEMENT.

4. Indemnification by Payer. Payer agrees to indemnify, defend and hold Emdeon harmless from and against any Losses resulting from any infringement of a U.S. patent, copyright, trademark, trade secret or similar intellectual property right of a third party resulting from Payer's unauthorized use or modification of the Emdeon IP; provided, however, that Payer shall have no obligation to indemnify, defend or hold Emdeon harmless with respect to such third party claims unless Emdeon promptly notifies Payer in writing of the claim, allows Payer to control the defense of such claim, and cooperates with Payer in the defense of the claim or in any related settlement negotiations.

F. Warranties.

DISCLAIMER OF WARRANTIES. EXCEPT FOR THE LIMITED WARRANTIES EXPRESSLY SET FORTH IN THIS AGREEMENT AND THE SELECTED SERVICES SCHEDULE(S), EMDEON MAKES NO PROMISES, REPRESENTATIONS OR WARRANTIES CONCERNING THE EMDEON PRODUCTS AND SERVICES OR THE EMDEON MATERIALS. EMDEON DISCLAIMS, FOR ITSELF AND ANY THIRD PARTY LICENSORS, ANY AND ALL OTHER EXPRESS OR IMPLIED REPRESENTATIONS AND WARRANTIES WITH RESPECT TO THE EMDEON PRODUCTS AND SERVICES AND THE EMDEON MATERIALS PROVIDED HEREUNDER, INCLUDING ANY EXPRESS OR IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, WARRANTIES CONCERNING INFRINGEMENT, TITLE, CONDITION OR THE EXISTENCE OF ANY LATENT OR PATENT DEFECTS, WARRANTIES ARISING FROM COURSE OF DEALING, USAGE OR TRADE PRACTICE, OR WARRANTIES THAT THE EMDEON PRODUCTS AND SERVICES AND THE EMDEON MATERIALS WILL BE UNINTERRUPTED, ERROR-FREE OR COMPLETELY SECURE.

G. Limitation Of Liability.

1. LIMITATION ON CUMULATIVE LIABILITY. EXCEPT FOR ANY LIABILITY ARISING OUT OF EMDEON'S INDEMNIFICATION OBLIGATIONS, THE CUMULATIVE LIABILITY OF EMDEON TO PAYER FOR ANY ACTUAL OR ALLEGED

DAMAGES ARISING OUT OF, BASED ON OR RELATING TO THIS AGREEMENT, WHETHER BASED UPON BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), WARRANTY OR ANY OTHER LEGAL THEORY, SHALL NOT EXCEED THE AMOUNT OF THE PROCESSING FEES PAID UNDER THIS AGREEMENT BY PAYER TO EMDEON FOR THE APPLICABLE EMDEON PRODUCT OR SERVICE INVOLVED DURING THE ONE (1) YEAR PRECEDING PAYER'S CLAIM.

2. LIMITATION ON SPECIFIED DAMAGES. IN NO EVENT SHALL EMDEON OR ITS THIRD PARTY LICENSORS BE LIABLE TO PAYER FOR ANY INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR EXEMPLARY DAMAGES (INCLUDING DAMAGES RELATED TO DELAYS, LOSS OF DATA, INTERRUPTION OF SERVICE OR LOSS OF BUSINESS OR PROFITS OR REVENUE), EVEN IF EMDEON OR SUCH THIRD PARTY LICENSORS HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. EXCEPT AS SET FORTH IN SECTION 3.E, IN NO EVENT SHALL EMDEON OR ANY THIRD PARTY LICENSOR BE LIABLE FOR ANY THIRD PARTY CLAIM.

3. Assertion of Claims. Any claim or cause of action arising out of, based on, or relating to this Agreement not presented by Payer within one (1) year from the discovery of the claim or cause of action shall be deemed waived. Payer shall have the duty to mitigate damages for which Emdeon may become responsible under this Agreement.

H. Miscellaneous.

1. Compliance with Laws. The parties shall comply with all applicable federal, state and local laws, and each party shall secure any license, permit, or authorization required by law in connection with this Agreement.

2. Independent Contractors. The parties will act as independent contractors and this Agreement does not constitute either party as the agent or partner of the other party.

3. Notices. Notices hereunder shall be in writing, signed by an officer of the notifying party, and delivered via facsimile, personally or sent by registered or certified mail, charges prepaid, or overnight courier service to the addresses noted in this Agreement (or to such other address as the recipient may have previously designated by written notice), and will be deemed given when so delivered or four days after the date of mailing, whichever occurs first, or upon electronic confirmation of delivery via facsimile transmission. All notices delivered to Emdeon should be sent with a copy to Emdeon Business Services, Attention General Counsel, 3055 Lebanon Pike, Nashville, Tennessee 37214. All notices delivered to Payer should be sent to CalOptima, Attention: Mark Finch, C.P.M., CPPO, 1120 West La Veta Avenue, Orange, CA 92868.

4. Assignment. Neither party shall assign, sell or otherwise transfer this Agreement or any rights hereunder without the express prior written consent of the other party, which consent shall not be unreasonably withheld. An assignment hereunder shall be deemed to include the transfer of control or a majority equity ownership of Payer. Notwithstanding the foregoing, Emdeon may terminate this Agreement in its sole discretion, if Payer merges or consolidates with a competitor of Emdeon, effective immediately upon notice to Payer. Furthermore, any purported assignment or transfer in violation of this section shall be null and void, and shall entitle the non-assigning party to terminate this Agreement effective immediately upon notice to the assigning party. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and assigns.

5. Third Parties. Except as expressly set forth herein, nothing in this Agreement shall be construed as giving any person or entity, other than the parties hereto and their successors and permitted assigns, any right, remedy or claim under or in respect of this Agreement or any provision hereof, provided that Emdeon's third party licensors shall be third-party beneficiaries to this Agreement.

6. Force Majeure. Except for Payer's payment obligations hereunder, neither party shall be responsible for delays or failures in performance resulting from acts or events beyond its reasonable control, including but not limited to, acts of nature, governmental actions, fire, labor difficulties or shortages, civil disturbances, transportation problems, interruptions of power, supply or communications or natural disasters, provided such party takes reasonable efforts to minimize the effect of such acts or events.

7. Entire Agreement/Severability. No representations have been made to induce either party to enter into this Agreement except for the representations explicitly stated in this Agreement. This Agreement supersedes all prior or contemporaneous written or oral agreements or expressions of intent or understanding and is the entire agreement between the parties with respect to its subject matter. In the event of a conflict or inconsistency between the General Terms and Conditions and the terms and conditions of any of the Services Schedules, the terms and conditions of the Services Schedule shall take precedence. If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way. The invalid, void or unenforceable provisions shall be adjusted rather than voided, if possible, in order to achieve the intent of the parties to this Agreement to the extent possible, unless such modification would materially alter the original intent of this Agreement. All terms, conditions or provisions which may appear on any purchase or sales order or invoice issued pursuant to this Agreement, to the extent inconsistent with the terms and conditions of this Agreement, shall be of no force or effect, notwithstanding the fact that such order or invoice may have been executed subsequent to the date of this Agreement, and, in any event, preprinted terms of any such order or invoice shall have no force or effect.

8. Amendment. This Agreement cannot be terminated (other than as set forth herein) or changed except pursuant to a writing signed by an authorized officer of Emdeon and an authorized officer of Payer. No waiver of any of the provisions of this Agreement shall be effective unless in writing and signed by an authorized officer of the party charged with such waiver and any such waiver shall be strictly limited to the terms of such writing.

9. Costs. Except as expressly set forth herein, each party shall bear its own costs, expenses, taxes and other charges whatsoever incurred in connection with the execution and performance of this Agreement.

10. Announcements. All media releases, public announcements or other public disclosures by Payer or its employees or agents relating to this Agreement or its subject matter, including without limitation, promotional or marketing materials, shall be coordinated with and approved by an officer of Emdeon prior to release, but this restriction shall not apply to any disclosure solely for internal distribution by Payer or any disclosure required by legal, accounting or regulatory requirements.

11. Counterparts. This Agreement and any amendments hereto may be executed in one (1) or more counterparts, each of which shall be an original, but all of which together shall constitute one (1) instrument.

12. Headings. The section headings of this Agreement are inserted for reference and convenience purposes only and do not constitute a part, nor shall affect the meaning or interpretation of, this Agreement.

13. Governing Law. This Agreement is governed by the laws of the State of California both as to interpretation and enforcement, without regard to the conflicts of law principles of that State. Exclusive jurisdiction and venue for any dispute relating to this Agreement shall reside in (i) any state court of competent jurisdiction sitting in Orange County, California if such a dispute is brought by Emdeon or (ii) any state court of competent jurisdiction sitting in Davidson County, Tennessee if such a dispute is brought by Payer. The parties agree and expressly consent to the exercise of personal jurisdiction in said court in connection with any such dispute.

14. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of Payer under this Agreement are solely the obligation of Payer, and the County of Orange, State of California, shall have no obligation or liability therefor.

15. Prohibited Interests. Emdeon represents that, for the term of this Contract, no director, member, officer, or employee of Payer during his/her tenure has any interest, direct or indirect, in this contract, agreement or purchase order, or the proceeds thereof.

16. Offshore Performance.

a. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by Payer.

b. Emdeon acknowledges that Payer requires Emdeon to obtain approval from it of Emdeon's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential Payer Member information, including, but not limited to, protected health information. Emdeon represents and warrants that it has disclosed to Payer any and all such offshore subcontractors and that it has obtained Payer's written approval to use such offshore subcontractors prior to the effective date of this Agreement.

c. Any new subcontract with an offshore entity under which the offshore entity will have access to any confidential Payer Member or other protected health information must be approved in writing by Payer prior to execution of the subcontract.

d. Unless specifically stated otherwise in this Agreement, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the underlying contracted services under the Agreement, such as development work, testing IT support tasks and customer support services.

e. The provisions of this Section apply to work performed by subcontractors at all tiers.

17. California Public Records Act. As a local public agency, Payer is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). Emdeon hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. Payer may be required to reveal certain information believed to be proprietary or confidential by Emdeon pursuant to the Public Records Act. In the event that Emdeon discloses information which it believes to be proprietary or confidential to Payer, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless Emdeon marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies Payer in writing that Emdeon has so marked each piece of material, then Payer will not be responsible to take any actions to protect any of Emdeon's materials under the Public Records Act that are not so marked. In the event Payer receives a request under the Public Records Act that potentially encompasses Emdeon materials that have been properly marked, Payer will provide Emdeon with prompt notice thereof to allow Emdeon to take actions it deems appropriate to prevent disclosure of the marked material, including, but not limited to, seeking an injunction. In addition, Payer will cooperate with Emdeon in its attempt to prevent disclosure of the marked material to the extent allowed under the Public Records Act. Emdeon agrees to waive its right to bring any claim, action or other proceeding against Payer for any liability, loss, damage, cost or expense arising out of Payer's compliance with the Public Records Act so long as Payer acted in accordance with this Section 3.H.17. and provided Emdeon notice of requests of Emdeon marked material in a time and manner allowing Emdeon to take the necessary actions to protect its confidential information.

SIGNATURES ON FOLLOWING PAGE

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS AGREEMENT TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA

"PAYER"

Address: 1120 West La Veta Avenue
Orange, CA 92868
Phone: 714/246-8660
Fax:

By: Michael Engelhard

Name: MICHAEL ENGELHARD

Title: CFO

Date: 9/1/11

Tax ID Number:

ENVOY LLC, an Emdeon company

Address: 3055 Lebanon Pike
Nashville, TN 37214
Phone: (615) 932-3000
Fax: (615) 340-6049

By:

Name: Lowell Stokes

Title: Vice President, Deputy General Counsel

Date: MAR 25 2011

Emdeon E-Services Schedule

This Emdeon E-Services Schedule by and between Envoy LLC, an Emdeon company ("Emdeon"), and **ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA** ("Payer") sets forth the specific terms and conditions governing Payer's use of the Emdeon E-Services, and is incorporated into the Emdeon Payer Agreement ("Agreement").

SECTION 1 - SERVICES.

Payer selects E-Services (for purposes of this Schedule, the "E-Services") set forth in Exhibit A to this Schedule.

SECTION 2 - DEFINITIONS.

2.1. "Affiliate" shall mean any entity owned or controlled by, under common ownership or control with, or which owns or controls either party or any of its subsidiaries.

2.2. "E-Services Effective Date" shall mean the date this Schedule is signed by Emdeon

2.3. "EDI Materials" shall mean all specifications and materials (including but not limited to any and all training materials, EDI Specifications, designs and design documents, information manuals, and all other documentation) pertaining to E-Services supplied to Payer by Emdeon.

2.4. For purposes of this Schedule, "EDI Products" shall mean all equipment, hardware, firmware and software (whether in source or object code form), and all modifications, updates, enhancements, or replacements for any of the foregoing furnished to Payer by Emdeon to facilitate use of the E-Services, including but not limited to those specified in this Schedule.

2.5. "Submitters" shall mean the entities, including, without limitation, direct submitting providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insured organizations, managed care organizations, TPAs, PPOs, fee negotiators, governmental agencies and other entities providing transaction submission services who are authorized by Emdeon and Payer to submit Transactions through the E-Services on behalf of Payer.

2.6. "EDI Specifications" shall mean the specifications published by Emdeon in effect from time to time applicable for each specific Transaction and similar documentation relating to the E-Services.

2.7. "Transactions" shall mean transactions submitted to E-Services by Submitters, whether or not Payer accepts, adjudicates or re-prices such transactions.

2.8. "Batch Transactions" shall mean transactions initiated and processed during separate telecommunication sessions.

2.9. "Real-Time Transactions" shall mean transactions initiated, processed and a response returned to the initiating party during the same telecommunications session.

SECTION 3 - PAYER'S RIGHTS TO USE THE E-SERVICES.

3.1. Subject to the terms and conditions of this Agreement, Emdeon grants to Payer a non-exclusive and non-transferable license right for the term of this Agreement to use the E-Services and, if applicable, the EDI Products, in accordance with the EDI Specifications for the applicable Transactions only at physical site(s) owned or managed by or under the control of Payer solely for Transactions being submitted on behalf of Payer or any of its Affiliates. Payer shall utilize E-Services solely for the purpose of facilitating use of E-Services and only in compliance with the procedures and guidelines set forth in the EDI Specifications. No rights are granted to the E-Services except as explicitly set forth in this Agreement.

3.2. Except for the EDI Products specifically identified in this Schedule, Payer shall be solely responsible for acquiring, operating and maintaining hardware and software with respect to Payer's use of the E-Services, Emdeon shall have no responsibility for any costs incurred in connection with modifications or enhancements to Payer's system necessary for implementing Payer's interface with the E-Services or in connection with Payer's use of the E-Services, unless otherwise expressly set forth in this Schedule.

3.3. Emdeon may from time to time in its sole discretion, without liability to Payer, suspend, revise, modify, update or replace any E-Services and EDI Products in whole or in part; provided the E-Services are not adversely affected in any material manner and Emdeon notifies Payer of any such event, either electronically or in writing, with reasonable promptness after determining that such event will occur. Emdeon shall furnish Payer with appropriate EDI Materials in connection therewith in a manner reasonably calculated to allow implementation and testing by Payer before the effective date of such event.

SECTION 4 - FEES.

4.1. Payer shall pay Emdeon the fees and charges set forth in Exhibit A to this Schedule in a timely fashion as required by this Agreement.

4.2. Emdeon may at any time without prior notice pass through any applicable access fees and/or increase in communications tariffs related to the E-Services, including, without limitation, government imposed access fees, fees resulting from changes in regulation or statute or any third party imposed access fees related to the E-Services, or any other fees assessed against Emdeon and outside of Emdeon's reasonable control. Upon request, Emdeon shall make available to Payer documentation relating to these pass through fees in connection with the E-Services. In the situation where any new or increased pass through fees increase the cost to Payer by ten percent (10%) or more of the then current cost to Payer, Emdeon will provide notification and reasonable supporting documentation to Payer without unreasonable delay.

4.3. If Payer fails to provide an average response time for any Real-Time Transaction of seven (7) seconds or less, Emdeon may request at any time a price increase for such Transaction. If Payer fails to accept such price increase at the time requested by Emdeon, Emdeon shall have the right to terminate the use of the E-Services for such Transactions.

4.4. Any technical support, software customization or training services requested in writing by Payer which are not required to be performed by Emdeon hereunder shall be evidenced by an Amendment, subject to the availability of Emdeon's technical staff and shall be billed at Emdeon's then current time and material rates plus out-of-pocket expenses, and subject to such other terms and conditions which may be agreed upon in writing by the parties before such services are performed.

4.5. Any optional enhancements, modifications, features, modules or products that may from time to time be developed by Emdeon with respect to the E-Services will be offered to Payer and, if Payer elects to utilize such enhancements, modifications, features, modules or products, Payer shall pay applicable fees, if any.

SECTION 5 - TERM.

Except as otherwise expressly set forth in the Agreement, the initial term of this Schedule shall commence on the E-Services Effective Date and shall continue for a period of one (1) year thereafter, with up to four (4) one (1) year renewals, subject to Payer's discretion.

SECTION 6 - IMPLEMENTATION.

6.1. Commencing promptly after the Effective Date, Payer and Emdeon shall use commercially reasonable efforts to implement the E-Services for Payer in accordance with the Emdeon implementation procedures (the "Implementation Phase"). Each party shall designate a project manager who will work with their counterpart to develop and agree upon the specific implementation plan and schedule in accordance with the Implementation Procedures which will include the projected date for the commencement of the use of the E-Services by Payer (the "Projected Live Date"). During the Implementation Phase, Emdeon shall assist Payer in implementing the E-Services, add Payer to the Emdeon system, receive from and submit to Payer test data and provide the technical support and training services as reasonably required to bring Payer to a live status ready to use the E-Services. Until the Acceptance Date (as defined in Section 6.2 below), Payer shall utilize the E-Services solely for implementation and testing of such E-Services to determine acceptability.

6.2. Payer shall notify Emdeon no later than five (5) business days before the Projected Live Date if Payer determines that the E-Services are not acceptable because such do not conform to the EDI Specifications and EDI Materials. With such notice Payer shall identify with specificity the discrepancies between the E-Services as delivered and the E-Services as described in the EDI Specifications and EDI Materials. Emdeon shall then have twenty (20) business days to correct such discrepancies and Payer shall have an additional fifteen (15) business days following delivery of the corrected E-Services to evaluate the E-Services for acceptability. If Payer still reasonably determines that the E-Services fail to conform to the EDI Specifications and EDI Materials, Payer shall (a) give written notice to Emdeon of its decision not to accept the E-Services, (b) treat this Agreement as immediately terminated without any obligation imposed on Payer to make any further payment for the E-Services, and (c) take all action required under Article 3.B of the General Terms of the Agreement. Thereafter, neither party shall have any further obligation to the other except that both parties shall continue to be bound by the provisions relating to confidentiality hereunder. If Payer fails to give notice to Emdeon of a rejection of the E-Services by the fifth (5^{th}) business day before the Projected Live Date, the E-Services shall be deemed accepted. The Projected Live Date or, where applicable, the date the E-Services are accepted by Payer after a notice of discrepancy under this Section 6.2 shall be deemed for all purposes of this Agreement as the "Acceptance Date". Notwithstanding the foregoing, if Payer has not "accepted" the E-Services and completed the Implementation Phase within one-hundred eighty (180) days of Effective Date, Emdeon in its sole discretion may terminate this Agreement immediately upon written notice to Payer.

SECTION 7 - EMDEON OBLIGATIONS.

7.1. Emdeon shall perform services in accordance with Payer's Exhibit B Scope of Services which is attached hereto and incorporated herein.

7.2. Emdeon shall operate the E-Services in accordance with the EDI Specifications applicable to each such EDI Service, and the E-Services shall be available to Payer during the hours designated in the EDI Specifications. Emdeon may change such hours of availability with reasonable advance notice if such change is applicable to all entities participating in the E-Services in like manner as Payer with substantially equivalent or greater Transaction volume as Payer.

7.3. Batch Transactions through the E-Services shall be transmitted in batch mode within twenty-four (24) hours of receipt by E-Services (excluding Saturdays, Sundays, and holidays) except as may otherwise be set forth in the EDI Specifications for such Transactions.

7.4. Real-Time Transactions through the E-Services shall be available seven (7) days a week, twenty-four (24) hours a day, except during planned downtime or as may otherwise be set forth in the EDI Specifications for such Transaction.

7.5. In the event that Payer requests Emdeon to effect modifications or enhancements in the E-Services, EDI Products, or any related

software to accommodate specific Payer requirements, Emdeon shall promptly after receiving such request, evaluate the requirements and provide Payer a proposal setting forth a description of the changes and/or development involved, cost estimates, projected time for completion and other appropriate terms and conditions, and, if Payer accepts such proposal in writing evidenced by an Amendment, Emdeon shall use commercially reasonable efforts to complete the development effort in accordance with such proposal. Upon completion of the changes necessary to effect such proposal, the fees and charges provided for in Article 4 above may be superseded and, if so superseded, Payer shall thereafter pay for fees and charges as set forth in Emdeon's proposal.

7.6. Emdeon shall respond to inquiries and complaints from Submitters directly relating to the transmission of Transactions through the E-Services and refer to Payer inquiries and complaints it receives from Submitters with respect to Payer which do not relate to such transmission of Transactions through the E-Services.

7.7. Emdeon shall maintain all records and correspondence relating to Payer's use of the E-Services for a period which shall be the greater of that required by applicable law or ten (10) years after the termination or expiration of this Agreement. Emdeon shall, and is hereby authorized by Payer to, make such records and correspondence available for examination, audit and inspection by any applicable regulatory agency.

7.8. Emdeon shall provide reasonable ongoing technical support through telephone consultations with respect to the E-Services and shall provide a local or alternative toll free telephone number for access to Emdeon's technical support facility for this purpose. In addition, if determined to be necessary by Emdeon and Payer, Emdeon shall provide on site visits to assist Payer in using the E-Services. Emdeon shall not charge for such visit unless the visit is requested by Payer and not determined to be necessary by Emdeon, in which case such visits in excess of once per year shall be subject to the availability of Emdeon's support staff and may be charged to Payer at Emdeon's then time and material rates for such support (which rates shall be made available to Payer by Emdeon from time to time at Payer's request) plus reasonable out-of-pocket expenses.

7.9. Emdeon agrees to participate in quarterly conference calls related to Contract Administration.

7.10. Emdeon shall perform, at its election, automated data checks of the data submitted through the E-Services for completeness, logic, and satisfaction of statistical requirements of the then applicable EDI Specifications. Payer acknowledges any Transactions not in compliance with such requirements will be rejected.

7.11. Emdeon agrees to produce an SAS70 or equivalent report to Payer upon its reasonable request.

SECTION 8 - PAYER OBLIGATIONS.

8.1. Payer agrees to receive and accept from Emdeon all Transactions submitted through the E-Services by a Submitter for routing to Payer (or Payer's designated agent) and otherwise to participate in and perform its obligations hereunder relating to the E-Services. In furtherance hereof:

a) Payer shall operate its system to ensure that Emdeon may at all times telecommunicate directly with Payer for the E-Services without the requirement that Emdeon communicate with or through any third party on each business day in accordance with the applicable EDI Specifications commencing promptly following the Acceptance Date; and

b) Payer shall accept all Transactions submitted through the E-Services to Payer each business day.

8.2. Payer shall use the E-Services for all Transactions only in accordance with the procedures, data element standards, formats, codes, protocols and edits as are set forth in the then relevant EDI Specifications for such Transactions. Payer shall promptly report to Emdeon any performance problems related to the E-Services including a description of the circumstances surrounding their occurrence. Payer shall conform to any non-optional modification, feature, enhancement, module or product of the E-Services within the number of days (not less than ninety (90) days) which Emdeon shall designate in the notice regarding such change.

8.3. Payer shall maintain a telephone number for Submitters and answer telephonic inquiries from Submitters regarding electronic submission procedures in connection with the E-Services and assist Emdeon in providing status reports of claims in process. Payer also shall handle inquiries and complaints from Submitters concerning any matter other than a matter regarding the use by the Submitter of the E-Services, including questions concerning Payer's handling of claim re-pricing, claim settlements, claim denial or coverage questions in general. Any such inquiries or complaints received by Emdeon shall be referred by Emdeon to Payer for resolution.

8.4. If Real-Time Transactions are selected in Exhibit A:

a) Payer shall not access and shall take no action to obtain access to any information resident on the Emdeon system, except for data, reports and messages relating to Real-Time Transactions submitted to or received by Payer.

b) Except for reasonable periods of scheduled downtime, Payer shall accept the submission of Real-Time Transactions and respond to Real-Time Transactions interactively Monday through Saturday for eighteen (18) hours per day which shall include 7:00 A.M. Central Time through 10:00 P.M. Central Time plus 7:00 A.M. Central Time through 7:00 P.M. Central Time on Sunday. The term "respond" for this purpose shall mean such term as defined in the EDI Specifications. Payer also shall furnish to Emdeon reasonable advance notice of any scheduled suspension of services for Real-Time Transactions and shall advise Emdeon promptly following any unscheduled suspension of such services.

c) Payer's system shall provide to the Submitter of Real-Time Transactions a final resolution message for ninety percent (90%) of all Real-Time Transactions received through the E-Services within seven (7) seconds of receipt of each such Transaction.

8.5. With respect to Transactions submitted by Payer to the E-Services (e.g. Real-Time Eligibility Responses, Claim Status Responses, Roster Batch Transactions, Electronic Remittance Advice), Payer shall guarantee that the same data available through means other than the E-Services to requesting entities using the E-Services for such Transactions shall be available to each such entity through the E-Services.

8.6. Payer shall provide Emdeon a list of all of the Submitters of Payer one time per calendar year during the Term of this Agreement. Such information shall be provided disk formatted in accordance with Emdeon's then standard EDI Specifications.

8.7. Payer shall provide the following support to assist Emdeon in Submitter adoption of the E-Services: (a) provide reasonable assistance to the Submitters community regarding the use of the E-Services such as furnishing messages on re-pricing pages, on explanation of benefit statements, supporting the use of electronic transmissions or furnishing other substantially similar promotional material to Submitters; and (b) provide Emdeon with a listing of Submitters using paper methods to create a phone campaign to increase adoption of E-Services.

8.8. Payer and Emdeon each agree that the other shall retain records relative to Payer's and Emdeon's use of the E-Services in accordance with sound business practices and Emdeon and Payer may request access to such records as are reasonably necessary to examine Payer's and Emdeon's compliance with its obligations and the E-Services provided pursuant to this Agreement during normal business hours upon reasonable advance prior notice.

SECTION 9 - REPRESENTATIONS AND WARRANTIES.

9.1. Emdeon represents and warrants that the E-Services and EDI Products provided hereunder shall conform to the applicable EDI Specifications in all material respects. In the event of a documented and reproducible flaw in the E-Services inconsistent with these warranties are discovered, Emdeon's sole responsibility shall be to use commercially reasonable efforts to correct such flaw in a timely manner. These warranties do not apply to any media or documentation which has been subjected to damage or misuse or to any claim resulting, in whole or in part, from a breach of Payer's obligations hereunder or from any changes in the operating characteristics of computer hardware or computer operating systems which are made after the release of the applicable EDI Product or EDI Service, or which resulted from problems in the interaction of the E-Services with non-Emdeon software or equipment, or from breach by Payer of its obligations hereunder.

9.2. In the event information to be transmitted through the E-Services is not transmitted by Emdeon or is not accurately transmitted as a result of Emdeon's failure to perform the E-Services in accordance with the terms of this Agreement and such failure results in damage to Payer, then Emdeon's sole obligation and liability to Payer for such event (subject to reasonable mitigation by Payer and the limitations of liability set forth in Article 3.G of the General Terms) shall be limited to furnishing credits on subsequent invoices from Emdeon to Payer in an aggregate amount equal to Payer's actual damages incurred for retransmitting the data, including reasonable out-of-pocket expenses (subject to reasonable mitigation by Payer) which Payer can demonstrate it has sustained and which are directly attributable to such failure. Other than as expressly set forth in this Section 9.2, Emdeon shall not be liable for any actual monetary loss resulting from the event or from acts or omissions of Payer or any third party in reliance on data to be transmitted or transmitted through the E-Services, whether or not transmitted or transmitted accurately or inaccurately. Payer further agrees that Emdeon shall not be liable in any way for any inaccuracy which can be attributed to or demonstrated as resulting from errors or omissions or negligent or other wrongful acts of any employee of Payer, its Affiliates, or of the applicable Submitters. Any claim against Emdeon by Payer must be asserted in writing within sixty (60) days after Emdeon should have transmitted accurate information received from a Submitter or the transmission of inaccurate information on which the claim is based, whichever is applicable. Payer hereby agrees to promptly supply to Emdeon documentation reasonably requested by Emdeon to support any claim of Payer. THIS SECTION STATES THE ENTIRE LIABILITY OF EMDEON WITH RESPECT TO CLAIMS THAT INFORMATION WAS NOT TRANSMITTED OR WAS TRANSMITTED INACCURATELY BY EMDEON AND SUCH LIABILITY IS FURTHER LIMITED BY THE LIMITATIONS OF LIABILITY APPEARING IN SECTION 3.G OF THE GENERAL TERMS AND CONDITIONS.

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS SCHEDULE TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE E-SERVICES EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA	**ENVOY LLC, an Emdeon company**
"PAYER"	
By: Michael Engelhard	By:
Name: MICHAEL ENGELHARD	Name: Lowell Stokes
Title: CFO	Title: Vice President, Deputy General Counsel
Date: 9/6/11	Date: MAR 25 2011

EMDEON E-SERVICES SCHEDULE - EXHIBIT A (Pricing)

Annual Service Fees:
Paid Annually — $ **WAIVED**

Batch Transaction Services:	**Implementation Fees Per Payer ID**	**Per Transaction Fee**
Core Claiming Services*:		
☒ Claims/Encounters to Payer, non-repriced (from Providers and Vendors)		
☒ Professional (Medical) Claims	$ **WAIVED**	$ 0.25 per claim
☒ Institutional (Hospital) Claims	$ **WAIVED**	$ 0.25 per claim

* The parties agree that Payer shall pay for all claims delivered to Payer by Emdeon after passing through Emdeon edits.

AGREED AND ACKNOWLEDGED:

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA	**ENVOY LLC, an Emdeon company**
"PAYER"	
By: Michael Engelhard	By:
Name: MICHAEL ENGELHARD	Name: Lowell Stokes
Title: CFO	Title: Vice President, Deputy General Counsel
Date: 9/6/11	Date: MAR 25 2011

** CONFIDENTIAL AND PROPRIETARY INFORMATION BETWEEN CALOPTIMA AND EMDEON **

EXHIBIT B

SCOPE OF SERVICES
Claim Clearinghouse Services

Objective:

Allow providers to submit claims data electronically in multiple formats inclusive of those accepted by the State Medi-Cal program for claims (ANSI 837, NSF, Proprietary, etc.) and forward those files to Payer in an ANSI-compliant or otherwise stated format.

Clearinghouse Requirements

- Submit all provider claim transactions to Payer in a secure and compliant manner according to the ANSI standardized file layouts or State recognized requirements:
  - 837P/I
  - Long Term Care file converted to ANSI 837
- Ensure quality of files by checking for HIPAA errors in layouts and performing periodic audits to ensure compliance.
- Emdeon will guarantee that all claim files are sent to Payer within 48 hours of receipt from the provider. **Batch Claims received by Emdeon before 3 p.m. Eastern on a business day will be ready for Payer pick up by 8 a.m. Eastern the next day. Batch Claims received after 3 p.m. Eastern shall be deemed to be received the next business day.**
- Emdeon shall pro-actively communicate any issues prohibiting required turnaround times.
- Develop, test and implement all State and/or Federal regulated changes for new file formats and support Payer and its providers by communicating timelines and allowing for transition periods (i.e. HIPAA-regulated ANSI X12 004010a1 to 005010 transition).
- Emdeon will maintain and support member and provider level edits to reject claims back to providers within 24 hours.
- Provide reports on reject rates and activity by provider and a total record count daily for reconciliation.
- Emdeon will be able to receive Payer claims from other Clearinghouse to Emdeon's and convert them to Payer standards.
- Emdeon shall supply reasonable telephone support to Payer and its providers.
- Emdeon will assign a Account Manager that will provide Payer with one-on-one support and will ensure resolution to issues in a timely manner as follows:
  - Urgent issues will be acknowledged within 24 hours/resolved in no more than 14 calendar days, Routine issues will be acknowledged within 72 hours/resolved in no more than 30 business days
    - Urgent issues are defined as problems causing a cease in production claims files or HIPAA Level 1 or 2 errors found in files transmitted to Payer. Routine issues are all other issues.
- Emdeon shall provide reasonable support visits no more than once a year and as mutually agreed upon by the parties.

ADDENDUM TO AGREEMENT
Between
ENVOY LLC
and
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
D/B/A CALOPTIMA

The Emdeon Business Services Payer Agreement, by and between Envoy LLC, an Emdeon company ("Emdeon") and Orange County Health Authority, a Public Agency, d/b/a Orange Prevention And Treatment Integrated Medical Assistance d/b/a CalOptima ("Payer") dated as of September 1, 2011, and any addenda or riders thereto (collectively the "Agreement") is hereby amended as follows:

1. Section 2 – Selection of Emdeon Business Services of the Agreement is hereby amended to add the following Emdeon Service to the Emdeon Services currently selected by Payer:

   ☒ Emdeon Claims Payment and Communication Services (Governed by the additional Terms and Conditions outlined on **Emdeon Claims Payment and Communications Services Schedule** attached hereto)

2. The Addendum Effective Date shall be the date this document is signed by Emdeon.

3. The definitions of terms appearing in the Agreement shall apply to such terms as used in this Addendum.

4. Except as modified by this Addendum, the terms and conditions of the Agreement shall remain in full force and effect and this Addendum shall be deemed a part of the Agreement. In the event of a conflict between a provision of this Addendum and a provision of the Agreement, the provision of this Addendum shall govern.

AGREED TO AND ACCEPTED BY:

Orange County Health Authority, a Public Agency, d/b/a Orange Prevention And Treatment Integrated Medical Assistance d/b/a CalOptima

By: Michael Engelhard
Name: Michael Engelhard
Title: CFO
Date: 9/28/11
By: Richard Chambers
Name: Richard Chambers
Title: CEO
Date: 10/26/11

ENVOY LLC, an Emdeon company

By: [signature]
Name: Lowell Stokes
Title: ~~Vice President, Deputy General Counsel~~
Date: OCT 18 2011

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Emdeon Claims Payment and Communication Services Schedule

This Claims Payment and Communication Services Schedule (the "CPCS Schedule") by and between ENVOY LLC, an Emdeon company ("Emdeon"), and **Orange County Health Authority, a Public Agency, d/b/a Orange Prevention and Treatment Integrated Medical Assistance d/b/a CalOptima** ("Payer") is incorporated into the Emdeon Payer Agreement ("Agreement").

SECTION 1 - SERVICES.

Payer selects the following CPCS services (for purposes of this CPCS Schedule, the "CPCS Services"):

- ☒ Print and Mail
- ☒ Client Access System
- ☒ Healthpayers USA
- ☒ Terrorist Watch
- ☐ PDF Image Delivery
- ☒ Web API
- ☐ Electronic Remittance Advice ("ERA"):
  - ☐ Payer generated ERAs
  - ☐ Emdeon generated ERAs
- ☐ eEOB
- ☒ Intelligent Mail Service
- ☐ Other _____

SECTION 2 - DEFINITIONS.

2.1. "Claims Communications" shall mean any document type that Emdeon processes for Payer hereunder, which document types may include negotiable checks, remittance advices, explanation of benefits, provider statements, system letters or other informational requests, premium billing statements, HIPAA Certifications or COBRA notifications.

2.2. "CPCS Services Effective Date" shall mean the date this CPCS Schedule is signed by Emdeon.

2.3. "CPCS Materials" shall mean all specifications and materials (including but not limited to any and all training materials, CPCS Specifications, designs and design documents, information manuals, and all other documentation) pertaining to CPCS Services supplied to Payer by Emdeon.

2.4. "CPCS Specifications" shall mean the specifications published by Emdeon in effect from time to time applicable for each specific CPCS Service.

2.5. "System" shall mean the proprietary system developed by Emdeon to deliver the CPCS Services.

SECTION 3 - PAYER'S RIGHTS TO USE THE CPCS SERVICES.

3.1. Subject to the terms and conditions of the Agreement and this CPCS Schedule, Emdeon grants to Payer a non-exclusive and non-transferable right for the term of this CPCS Schedule to use the CPCS Services in accordance with the CPCS Specifications solely for Claims Communications created by Payer. No rights are granted to the CPCS Services except as explicitly set forth in this CPCS Schedule.

3.2. Payer shall be solely responsible for acquiring, operating and maintaining hardware and software with respect to Payer's use of the CPCS Services, Emdeon shall have no responsibility for any costs incurred in connection with modifications or enhancements to Payer's system necessary for implementing Payer's interface with the CPCS Services or in connection with Payer's use of the CPCS Services, unless otherwise expressly set forth in this CPCS Schedule.

3.3. Emdeon may from time to time in its sole discretion, without liability to Payer, revise, modify, update or replace any CPCS Services in whole or in part; provided the CPCS Services as delivered to Payer are not adversely affected in any material manner and Emdeon notifies Payer of any such event, either electronically or in writing, with reasonable promptness after determining that such event will occur. Emdeon shall furnish Payer with appropriate CPCS Materials in connection therewith.

SECTION 4 - FEES.

4.1. Payer shall pay Emdeon the fees and charges set forth in Exhibit A to this CPCS Schedule in a timely fashion as required by the Agreement and this CPCS Schedule.

4.2. Any technical support, software customization or training services requested in writing by Payer which are not required to be performed by Emdeon hereunder shall be subject to the availability of Emdeon's technical staff and shall be billed at Emdeon's then current time and material rates plus out-of-pocket expenses, and subject to such other terms and conditions which shall be agreed upon in writing by the parties before such services are performed.

4.3. Any optional enhancements, modifications, features, modules or products that may from time to time be developed by Emdeon with respect to the CPCS Services will be offered to Payer and, if Payer elects to utilize such enhancements, modifications, features, modules or products, Payer shall pay applicable fees, if any.

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SECTION 5 - TERM.

5.1. Except as otherwise expressly set forth in the Agreement, the initial term of this CPCS Schedule shall commence on the CPCS Services Effective Date and shall continue for a period of three (3) years thereafter. This CPCS Schedule shall then automatically renew for additional one (1) year terms unless either party gives notice to the other at least ninety (90) days before the end of the next expiration date of its decision not to renew this CPCS Schedule.

5.2. Upon termination or non-renewal of this CPCS Schedule for any reason: (a) Emdeon shall, within sixty (60) days following such termination, (i) return to Payer any excess funds in Payer's Postage Account (as such term is defined below) less any outstanding amounts due Emdeon, and (ii) return to Payer all of Payer's confidential or proprietary information (including electronic signature plates and online image files) in its possession, and (b) Payer shall, within thirty (30) days following such termination, pay to Emdeon any and all amounts owed Emdeon at the time of termination.

SECTION 6 - IMPLEMENTATION.

6.1. Commencing promptly after the Effective Date, Payer and Emdeon shall use commercially reasonable efforts to implement the CPCS Services for Payer in accordance with the Emdeon implementation procedures (the "Implementation Phase"). Each party shall designate a project manager who will work with their counterpart to develop and agree upon the specific implementation plan and schedule in accordance with the Implementation Procedures which will include the projected date for the commencement of the use of the CPCS Services by Payer (the "Projected Live Date"). During the Implementation Phase, Emdeon shall assist Payer in implementing the CPCS Services, receive from and submit to Payer test data and provide the technical support and training services as reasonably required to bring Payer to a live status ready to use the CPCS Services. Until the Acceptance Date (as defined in Section 6.2 below), Payer shall utilize the CPCS Services solely for implementation and testing of such CPCS Services to determine acceptability.

6.2. No later than five (5) business days before the Projected Live Date, Payer shall execute an "Authorization Order," which shall be substantially similar to the form contained within the CPCS Specifications, as final approval for Emdeon to begin the CPCS Services. Payer may provide the Authorization Order via email, facsimile, or regular mail. In the alternative, if Payer determines that the CPCS Services are not acceptable because such do not conform to the CPCS Specifications, Payer shall notify Emdeon no later than five (5) business days before the Projected Live Date of such determination. With such notice Payer shall identify with specificity the discrepancies between the CPCS Services as delivered and the CPCS Services as described in the CPCS Specifications. Emdeon shall then have twenty (20) business days to correct such discrepancies and Payer shall have an additional fifteen (15) business days following delivery of the corrected CPCS Services to evaluate the CPCS Services for acceptability. If Payer still reasonably determines that the CPCS Services fail to conform to the CPCS Specifications, Payer shall (a) give written notice to Emdeon of its decision not to accept the CPCS Services, (b) treat this CPCS Schedule as immediately terminated without any obligation imposed on Payer to make any further payment for the CPCS Services, and (c) take all action required under Article 3.B of the General Terms of the Agreement. Thereafter, neither party shall have any further obligation to the other except that both parties shall continue to be bound by the provisions relating to confidentiality hereunder. If Payer fails to give notice to Emdeon of a rejection of the CPCS Services by the fifth (5^{th}) business day before the Projected Live Date, the CPCS Services shall be deemed accepted. The Projected Live Date or, where applicable, the date the CPCS Services are accepted by Payer after a notice of discrepancy under this Section 6.2 shall be deemed for all purposes of this Agreement as the "Acceptance Date". Notwithstanding the foregoing, if Payer has not "accepted" the CPCS Services and completed the Implementation Phase within one-hundred eighty (180) days of the CPCS Services Effective Date, Emdeon in its sole discretion may terminate this Agreement immediately upon written notice to Payer.

SECTION 7 - EMDEON OBLIGATIONS.

7.1. Emdeon shall perform the CPCS Services in accordance with the CPCS Specifications applicable to each such CPCS Service.

7.2. Upon receipt of each Payer data file containing check data, Emdeon shall review the lesser of: (a) the immediately preceding six million (6,000,000) checks issued by Emdeon on behalf of Payer or (b) Emdeon's entire database with respect to checks previously issued by Payer within the immediately preceding six (6) month period, in order to protect against the issuance of a duplicate check. Payer hereby acknowledges that Emdeon makes no representations whatsoever as to the existence of any protection against the issuance of a duplicate check beyond that stated in the immediately preceding sentence. **Further, Payer acknowledges that any change to the field lengths or specific character positions, for transit number, account number or check number or any transposition of the individual characters (including special MICR characters) within the transit number, account number or check number in the Legacy System + Erisco Facets System (collectively, the "Systems") data extract will disable Emdeon's duplicate check detection process, in which event Emdeon makes no representations whatsoever as to the existence of any protection against the issuance of a duplicate check.**

7.3. Emdeon shall deliver all printed Claims Communications into the United States Postal Service mail stream within two (2) business days of the receipt of their corresponding data files from Payer, provided the data files are successfully received, imported and in release status by 10:00 a.m. central time (the "Cut-off Time"). If the data files are successfully received, imported and in release status after the Cut-off Time, Emdeon shall deliver Payer's printed Claims Communications into the United States Postal Service mail stream within three (3) business days of receipt.

7.4. Upon request, Emdeon will provide its standard document design support services to Payer at no additional cost.

7.5. During the term of this CPCS Schedule, Emdeon will store and maintain all warehoused images on behalf of Payer for a period of at least ten (10) years, in accordance with Emdeon backup protocol.

7.6. Emdeon shall provide standardized reports for accounting, audit, or general purposes as identified in the CPCS Specifications.

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The nature and content of any additional customized reports shall be established by Payer and Emdeon during the Implementation Phase, and Emdeon reserves the right to bill Payer for the creation of any such reports at Emdeon's then current hourly rate.

7.7. Upon Payer's request or approval, Emdeon shall utilize, at Payer's expense, a special delivery service entity acceptable to Payer (i.e., Federal Express or UPS) to handle all overnight, second day, or special delivery requirements of Payer's printed Claims Communications.

7.8. Emdeon and Payer shall each designate a minimum of two (2) employees as contact personnel to handle day-to-day processing issues. The name, phone number, fax number and e-mail address (if applicable) of each contact person shall be included in a contact list (the "Contact List") to be created and maintained between the parties.

7.9. Emdeon shall ensure that the personnel designated in the Contact List shall be available during the Implementation Phase for trips to Payer's facility, if mutually deemed necessary, to discuss any implementation issues that may arise. Emdeon agrees to pay for all travel and lodging expenses for its personnel.

7.10. Notwithstanding anything else to the contrary contained herein, Emdeon shall have the right to analyze and use the mailing addresses and geographic information of Payer's members, insured, enrollees and customers as well as the mailing addresses and geographic information of Payer's providers to optimize the delivery of the CPCS Services.

7.11. Emdeon may use Payer's name, or any logo, trademark, service mark, or other identification only with Payer's prior written consent. Upon termination of this CPCS Schedule, all such uses shall cease.

7.12. Emdeon shall maintain all records and correspondence relating to Payer's use of the CPCS Services for a period which shall be the greater of that required by applicable law or two (2) years after the termination or expiration of this CPCS Schedule. Emdeon shall, and is hereby authorized by Payer to, make such records and correspondence available for examination, audit and inspection by any applicable regulatory agency.

7.13. Any mutually agreed upon programming services will be billed by Emdeon to Payer at the rate of one hundred-fifty dollars ($150.00) per hour.

SECTION 8 - PAYER OBLIGATIONS.

8.1. Payer shall provide Emdeon, on a daily basis or such other timeframe mutually agreed upon in writing by Emdeon and Payer, with data files, in a mutually agreed upon format, that contain information necessary for Emdeon to provide the CPCS Services.

8.2. If during the term of this CPCS Schedule Payer uses claims administration software other than **the Systems**, and the claims administration software has a module designed for Emdeon to facilitate the CPCS Services (a "Module"), Payer agrees to: (a) acquire and utilize the Module for its designated purpose, unless a pre-existing data transfer mechanism for Emdeon has been created and is in use, and (b) pay Emdeon's standard five thousand dollar ($5,000) transition fee ("Transition Fee"). If Payer uses claims administration software other than **the Systems** and no Module exists for data transfers as described herein, Payer agrees to: (x) assist Emdeon in the development of a data transfer mechanism, (y) compensate Emdeon at its then current hourly rate for its efforts in developing the data transfer mechanism upon such terms as Emdeon and Payer shall mutually agree in writing, and (z) pay to Emdeon the Transition Fee.

8.3. Prior to Emdeon commencing the CPCS Services, Payer agrees to provide Emdeon with all pertinent information concerning Payer and Payer's customers as it relates to the processing of Claims Communications. This information, including but not limited to electronic signatures, document routing information, customer and Payer logos, bank name, bank logos, bank account information, authorization forms and any special handling information (together with the information outlined in Section 8.1, "Payer Information"), as is required to provide the CPCS Services. Emdeon shall have no independent duty to verify or confirm any Payer Information provided by Payer to Emdeon and Emdeon shall not be responsible for any errors that occur as a result of incomplete, incorrect or inaccurate Payer Information provided by Payer to Emdeon.

8.4. Payer shall ensure that its personnel designated in the Contact List shall be available during the Implementation Phase (defined above) for trips to Emdeon's processing facility, if mutually deemed necessary, to discuss any implementation issues that may arise. Payer agrees to pay all travel and lodging expenses for its personnel.

8.5. On or prior to the Acceptance Date, Payer agrees to pay to Emdeon an amount equal to two (2) months worth of Payer's estimated postage costs (the "Postage Deposit"). The Postage Deposit shall be calculated by multiplying Payer's monthly postage cost for the last full month prior to the Acceptance Date by two (2), or, if there are no previous month's postage costs, such other amount that the parties may mutually agree. Emdeon shall place the Postage Deposit into an account maintained by Emdeon for daily postage disbursements ("Postage Account"). Payer agrees to maintain a positive balance in its Postage Account during the term of this CPCS Schedule. Payer also agrees to increase the Postage Deposit amount to reflect any increases in monthly printed Claims Communication volume. Notwithstanding anything else to contrary, if at any time during the term of this CPCS Schedule, Payer's Postage Account falls below zero dollars ($0), Emdeon may suspend the CPCS Services on five (5) business days prior written notice.

8.6. Payer shall use its commercially reasonable efforts to assist and enable Emdeon to carry out its duties under this CPCS Schedule.

8.7. Payer shall not provide any of its customers with Emdeon's phone number or address without the prior written approval of Emdeon.

8.8. Payer hereby authorizes Emdeon to make all of the 835s, PDF images of remittance advice documents, postable files and data

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index fields that Emdeon creates on behalf of Payer hereunder, available to the applicable healthcare provider through Emdeon's products and services, including Emdeon Payment Manager, Accupost, and Emdeon's EDI clearinghouse.

8.9. Payer acknowledges and agrees that Payer is solely responsible for filing, and agrees to file, any and all governmental forms (including Form 1099s) that may be required by applicable law or regulation in regards to any Claims Communication check or payment that Payer submits to Emdeon for processing hereunder.

8.10. Payer acknowledges and agrees that Payer is solely responsible for complying with all Move Update requirements that allow Payer to receive United States Postal Services (USPS) presort mail discounts.

8.11. Emdeon has created and maintains a register of healthcare providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers (collectively "Providers") who have elected to replace the paper checks and/or paper remittance advice they currently receive from Emdeon with electronic counterparts. Payer hereby authorizes Emdeon to provide such Providers with electronic counterparts of their paper checks and/or paper remittance advice, which counterparts may include, but are not limited to, data files in standard formats (e.g. 835 ERAs and ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services, including Payment Manager, Accupost, and Emdeon's EDI clearinghouse in lieu of printing such documents.

SECTION 9 - REPRESENTATIONS AND WARRANTIES.

9.1. Emdeon represents and warrants that the CPCS Services provided hereunder shall conform to the applicable CPCS Specifications in all material respects. In the event of a documented and reproducible flaw in the CPCS Services inconsistent with these warranties is discovered, Emdeon's sole responsibility shall be to use commercially reasonable efforts to correct such flaw in a timely manner. If such flaw is not resolved within thirty (30) days, Emdeon shall provide to Payer a report outlining the details of the flaw and the estimated time for resolution. These warranties do not apply to any claim resulting, in whole or in part, from a breach of Payer's obligations hereunder or from any error, inaccuracy, mistake or delay caused by incomplete, incorrect or inaccurate information provided by Payer to Emdeon.

9.2. In the event that Payer is a third party administrator acting on behalf of its clients (e.g. employer groups, indemnity plans or self insured plans) ("Payer Clients"), Payer represents and warrants: (i) it has the authority to act on behalf of the Payer Clients in regards to this CPCS Schedule, (ii) on behalf of Payer Clients, it shall administer the implementation, access and use of the CPCS Services in accordance with the terms of this CPCS Schedule, and (iii) it shall defend, indemnify, and hold harmless Emdeon from and against any and all claims, losses or liabilities (including reasonable attorneys fees and expenses) arising, directly or indirectly, from any misrepresentation by Payer with regard to the existence and scope of its agency relationship with any Payer Client, including, without limitation, losses or liabilities arising from any misrepresentation concerning its authority to bind any Payer Client to this CPCS Schedule.

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS CPCS SCHEDULE TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE CPCS SERVICES EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA

"PAYER"

By: Michael Engelhard

Name: Michael Engelhard

Title: CFO

Date: 9/28/11

By: Richard Chambers

Name: Richard Chambers

Title: CEO

Date: 9/28/11

ENVOY LLC, an Emdeon company

By:

Name: Lowell Stokes

Title: Vice President, Deputy General Counsel

Date: OCT 18 2011

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EXHIBIT A

To Emdeon Claims Payment and Communication Services Schedule

Print Services Pricing

Emdeon Support Staff (Document design, changes, program updates):	No Charge
Implementation Fees:	
Print and Mail Services Implementation Fee:	**WAIVED**
WebAPI Services	$5,000.00
Domestic Postage:	At Cost
Foreign Postage:	The then current published USPS Global AirMail Letter Post Rates
Materials[1]**:**	
Secure Check Stock	$ 0.0209
White Paper Stock	$ 0.0099
Perforated White Paper (if required)	$ 0.0210
#10 Security Envelope	$ 0.0214
6X9 Envelope	$ 0.0350
9X12 Flat Envelope	$ 0.0990
1.5 inch corrugated box	$ 0.6450
2 inch corrugated box (if required)	$ 0.7450
3 inch corrugated box	$ 0.8950
4 inch corrugated box (if required)	$ 1.0400
4.5 inch corrugated box	$ 1.1650
Thermo Labels - Alternate Shipping	$ 0.2700
2 lb Mail Jacket (11X13.5) (if required)	$ 0.5300
1 lb Tyvek Envelope (if required)	$ 0.3100
#9 Business Reply Envelope (if required)	$ 0.0233
Emdeon Simplex Processing Fee:	$0.10/page
Additional Emdeon Duplex Processing Fee:	$0.05/page
Expedited USPS Fee (if used by Payer this is in addition to the applicable Emdeon Processing Fees):	$0.05/page
Intelligent Mail Service Fee:	$0.005 per envelope[2]
Online image storage and view:	$0.01/image
Online image written to DVD (if contract is terminated herein):	$0.0025/page
Client Access System:	**WAIVED**
Web API Hosting Fee:	$150.00 per month
Terrorist Watch Service:	$100.00 per month
Healthpayers USA:	50% of Savings[3]
Special Delivery Services (e.g., next day):	At Cost[4]

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1 In the event Emdeon experiences a cost increase on any of the Materials outlined above in an amount that is equal to or greater than fifteen percent (15%), Emdeon shall be entitled to pass through such increase immediately upon notice to Payer provided that, upon Payer's written request, Emdeon shall furnish Payer with written documentation evidencing such cost increase.

2 Emdeon reserves the right to pass along any Address Change Service fees that it may incur as a result of Payer's failure to update its addresses after receiving notification, from Emdeon or the USPS, of an updated address.

3 Savings shall be determined by Emdeon on a monthly basis and shall take into account savings achieved through postal consolidation with other clients.

4 These "at cost" charges are charged upon prior request and approval by Payer.

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Emdeon Claims Payment and Communication Services Specifications

Emdeon will perform the CPCS Services selected by Payer in accordance with the terms and conditions outlined in the Emdeon Business Services Payer Agreement and this Emdeon Claims Payment and Communication Services Specifications document.

I. EMDEON FILE TRANSMISSION PROCESS

A. FTP Process

Emdeon uses an FTP server allowing Payer to transmit data to Emdeon for processing. The FTP Process is defined below:

- Emdeon will provide a PGP-encryption key to Payer.
- Payer will PGP-encrypt all document files transmitted to Emdeon.
- Emdeon will provide FTP account information to Payer. This account is specific to Payer.
- Payer will acquire and utilize any commercially available FTP transfer program.
- Payer will transmit all document files to Emdeon via FTP.

B. Data Handling

Emdeon has several processes and procedures in place to ensure the integrity of Claims Communication data. The Data Handling process is defined below:

- Emdeon receives files from a Payer's claim processing system and then Emdeon performs verification of that file's uniqueness.
- The Emdeon FTP Server only allows for Zip or PGP files to be transferred. If the file is corrupted during transfer, the compressed files cannot be imported.
- The Emdeon System contains an index for each payer's check data built by concatenating "Check Number + Account Number + Transit Number". Emdeon maintains historic check data in the Emdeon system and the system audits for duplicate check numbers every time new data is sent to Emdeon. If a duplicate is found, the duplicate check record is rejected, and the Payer is notified immediately of the duplicate check.
- The Emdeon System automatically audits the entire MICR line, checking for valid characters on every check we receive. Emdeon places the MICR line based on the ANSI MICR specifications, and performs that function in a consistent manner for all checks created (1 set of rules within Emdeon System defines MICR line placement).
- Emdeon only maintains the MICR specs. The actual MICR line data is passed directly from the Payer's system through the data interface.
- The Emdeon System creates a summary check register based on the data received from Payer, which is emailed back to the client for verification. This is a "dual-control" function, because the Emdeon check register is created from "Printed Data", whereas the Payer's check register is created from "System Data".
- The Emdeon System automatically verifies delivery addresses against current postal data, and routes incomplete, undeliverable addresses back to Payer.
- The Emdeon System interfaces with Payer's claim system, and the interface allows Payer to flag individual claims for return to the Payer for additional oversight, review or processing.

II. PRINT AND MAIL SERVICE

A. Print Process

- Payer will transmit PGP-encrypted print files containing their Claims Communication data to Emdeon.
- Emdeon will decrypt the files, parse the file, and import the document data into the Emdeon System. During this process, a file receipt and a check register are generated and e-mailed to Payer.
- Prior to 10:00 a.m. Central time, Payer can access the Client Access System (defined below) to manage any successfully imported document. This management includes holds, releases, purges and re-routes.

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- At 10:00 a.m. Central time each business day, Emdeon will process the files eligible for processing since the last day's release. Emdeon will print the documents for mailing. Emdeon will also generate PDF images for all processed documents and make them available for on-line viewing within twenty-four (24) hours of processing.
- Payer may elect to have a production register distributed to them after the Emdeon processing. This file will contain information pertaining to the specific documents that were released for that day.

B. Insert Process

Emdeon uses a 2D barcode insertion process with full account sequencing, which allows all documents created by Emdeon to be tracked. The Insert Process is defined below:

- Machines log all insert transactions and categorize them as successful or unsuccessful (compromised).
- Since each user logs on to the machine to operate, all insert transactions are associated with the user.
- If any sheet is out of sequence or missing, the machine stops and the operator must research the discrepancy.
- If a duplicate print occurs (because the bar code is identical), the machine stops and the operator must intervene.

C. Automated Document Distribution and Oversight Controls

Automated Document Distribution and Oversight Controls are defined below:

- The Emdeon distribution rules (group rules) automate manual tasks with regard to the printing and distribution of documents for Payer.
- Emdeon automates all copy arrangements and distribution for Payer. Whenever Emdeon copies a check, the copy is generated on white paper and "Non-Negotiable" printed in the signature block(s).
- Emdeon shall establish audit controls for Payer with regard to high dollar checks. As an external process, this becomes a "dual control" scenario with Emdeon's audit parameters being the final check with regard to high dollar oversight situations. These high dollar checks are automatically routed to the designated party at Payer for review.
- ALL special handling performed by Emdeon for Payer is done and verified electronically within the Emdeon System. Error logs are created to notify Payer of missing, incorrect or incomplete information BEFORE anything is ever printed or distributed by Emdeon.

D. Manifest Mail Process

Emdeon's facility in Earth City, MO is a Mixed Weight Manifest Mail facility. The Mixed Weight Manifest Mail process is defined below:

- Emdeon sequences and trays all envelopes in zip code order across all payer mailings.
- United State Post Office (USPS) picks up trays from Emdeon on a daily basis.
- Due to its status as a Mixed Weight Manifest Mail facility, at no time is Emdeon required to go to a third party vendor for domestic USPS mail qualification or presort services. All domestic USPS mail generated by Emdeon is delivered into the postal system by Emdeon. No additional handling of the domestic USPS mail takes place and turnaround time can pick up from ½ to ¾ of a day on each end (send/deliver).
- Manifest Mail requires complete accuracy and compliance with USPS procedures. Mail trays are selectively audited by the USPS to ensure Emdeon's accuracy. This is an additional external check and balance for the Emdeon procedures.

III. CLIENT ACCESS SYSTEM (CAS)

The CAS is a tool that can be used by Payer to manage backend operations, by accessing data before and after the file transmission process. CAS allows clients to audit processes, change forms, change addresses, reroute distribution, send and view test files, manage errors and issues, and view documents and their distribution statistics. The following are features of CAS:

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- Address Manager – Allows Payer access to manage return of address information on outbound documents.
- Employer Group Manager – Allows Payer to add or modify new groups and lines of business to current parameters.
- File Receipt Manager* – Allows Payer to see the status of files sent to Emdeon and view the contents of the files.
- Business and Distribution Rules Manager – Allows payer's access to manage group or line of business distribution and special handling rules.
- Document Manager*# – Allows Payer to manage documents that have been imported into the Emdeon system. Operations include:
  - Hold – Keeps documents from being delivered and allows them to remain in data format in the Emdeon System. Payer can hold an entire file, groups/lines of business within a file and individual documents.
  - Release – Releases files and documents that are on hold.
  - Pull – Prints and delivers documents back to the client for review.
  - Purge – Purges documents from the system.
  - Route – Allows the delivery address and delivery type to be changed on documents after being sent to Emdeon.
  - History – Provides a full audit trail of all transactions and who authorized them.
  - Search – Provides the ability to search for a particular document and view/print the PDF image of the document.
- Test File Manager – Allows the Payer to submit test files and receive PDF output of new or altered information inputted by Payer in the previously listed capabilities.
- Security Manager – Allows Payer to manage logon accounts and configuration of individual employee access rights.
- Error Manager* – Allows the Payer to access information on any file errors and necessary steps to correct files before importing into the Emdeon System.

* File Receipt Manager, Document Manager, and Error Manager are the only features that will be made available to the Payer in the initial release of the Client Access System. Payer will be given access to additional features of CAS as Payer becomes more familiar with the Emdeon System.

\# Prior to 10:00 a.m. Central time, Payer can use CAS to manage any successfully imported document. This management includes holds, releases, purges and re-routes.

IV. PDF IMAGE DELIVERY SERVICE

Emdeon's PDF Image Delivery Service provides Payer with a PDF image of its Claims Communication. The PDF Image Delivery Service is defined below:

- Emdeon will create a PDF image of Payer's Claims Communications utilizing the data supplied by Payer to Emdeon in the data file.
- Once created, Emdeon shall forward the PDF images, along with a corresponding PDF image data file index, to Payer at an agreed upon location.
- The PDF image data file index shall contain information that will allow Payer to locate a given PDF image within the PDF image file.

V. WEB API SERVICE

Emdeon's Web API enables payers, providers, and members to request their claim documents over the internet. Web API is defined below:

- Emdeon utilizes URL-encryption; which appends encoded parameters to the base URL provided by Emdeon. Emdeon Web API simplifies this parameter encoding through one COM method call.
- Payer will use the Emdeon Web API for any of the Payer's document types.

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- Emdeon will provide documentation and consultation that will enable Payer to integrate Web API.

VI. HEALTHPAYERS USA SERVICE

Healthpayers USA is an Emdeon service that consists of seven (7) separate functions that are added to the Emdeon System to increase Emdeon's ability to optimize postage costs and mailing efficiencies. In order for Emdeon to perform such service on behalf of the Payer, the Payer will need to provide Emdeon with certain specific addressee information, including without limitation, addressee mailing address information, federal tax identification number ("TIN") information, paid claim information, and geographic information.

Healthpayers USA allows Emdeon clients to join together to lower postage and materials cost. Healthpayers USA is defined below:

1) **Cross Client Consolidation:**
   - Emdeon will consolidate Payer's Claims Communication with the documents of all other Emdeon clients that are using the Healthpayers USA service when all such documents are addressed to the same addressees.
   - Emdeon consolidates this mail by using addressee TIN or addressee name and mailing address to identify unique addressee matches.
   - Each day Emdeon will send one (1) envelope or package (a "Package") to each unique addressee on behalf of all Healthpayers USA users.
   - Emdeon will calculate Payer's postage costs by taking: (i) the number of pages in the Package that are attributable to Payer and dividing that number by the total number of pages going into the Package (collectively the "Multiplier"), and (ii) multiplying the Multiplier by the amount of postage that was used for the Package delivery. Emdeon will calculate Payer's materials cost for the Package by multiplying the Multiplier by the material's cost of the Package. Emdeon will calculate Payer's materials cost and processing fees for the Healthpayers USA cover sheet by multiplying the Multiplier by the material's cost of the coversheet and the Payer's processing fee, respectively. As an illustration, if the Payer was mailing a one page check/remit to Addressee A and three (3) other Emdeon clients were each also mailing 1 page check/remits to Addressee A, and all such clients (including Payer) were utilizing Healthpayers USA, Payer would be sending one (1) page out of a total of four (4) pages within such Package and the Payer would only be responsible for ¼th of the Package's postage and materials costs and ¼th of cover sheet's processing fees and material's cost. Nothing herein requires Emdeon to perform cross client consolidation for any Claims Communication containing incorrect or inaccurate TIN or mailing address information.

2) **Healthpayers USA Cover Sheet:**
   - Emdeon will insert a cover sheet into every cross client consolidated Package.
   - The cover sheet will describe the contents of each Package and the role of Emdeon as the consolidator/printer of the Claims Communications, as well as the provider of related electronic services.
   - The cover sheet will include Emdeon's return address.

3) **Return Mail Processing:**
   - All cross client consolidated mail that is deemed undeliverable by the USPS will be retuned to Emdeon.
   - To the extent reasonably possible, Emdeon will track, and re-route all returned Claims Communication within three (3) days of receipt by Emdeon.

4) **HPUSA Scheduler:**
   - If selected by Payer, HPUSA Scheduler allows Emdeon to determine which days of the week would maximize Healthpayers USA consolidation with other clients based on several factors including, line of business and geography, and to mail Payers documents on such days.

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5) **Multi-Location Printing:**

- In the event that Emdeon constructs additional print and distribution facilities, Multi-Location Printing will allow Emdeon to print Payer's documents from the Emdeon facilities that will maximize postage savings through discounts that Emdeon may become eligible for or that it may negotiate with the USPS or other commercial carriers.
- Any savings generated from such discounts will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings (as determined by Emdeon) in addition to the applicable Processing Fees.

6) **Elimination of certain paper Claims Communications to certain Providers:**

- Emdeon has created and maintains a register of healthcare providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers (collectively "Providers") who have elected to replace the paper checks and/or paper remittance advice they currently receive from Emdeon with electronic counterparts.
- Emdeon will provide such Providers with electronic counterparts of their paper checks and/or paper remittance advice, which counterparts may include, but are not limited to, data files in standard formats (e.g. 835 ERAs and ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services, including ERA Manager.
- Emdeon will be entitled to collect the Emdeon Processing Fees for any paper Claim Communications that is converted to its electronic counterpart as well as any other applicable fees (e.g. ACH Transaction Fees or ERA Fees). In addition, any savings generated from delivering such documents electronically will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings (as determined by Emdeon).

7) **Elimination of certain paper Claims Communications to certain Members:**

- Emdeon has created and maintains a register of payer members, insureds, enrollees and customers (collectively "Members") who have elected to replace the paper checks and paper explanation of benefits ("EOBs") they currently receive from Emdeon with electronic counterparts.
- Emdeon will provide such Members with electronic counterparts of their paper checks and/or paper EOBs, which counterparts may include, but are not limited to, data files in standard formats (e.g. ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services.
- Emdeon will be entitled to collect the Emdeon Processing Fees for any paper Claim Communications that is converted to its electronic counterpart as well as any other applicable fees (e.g. ACH Transaction Fees). In addition, any savings (as determined by Emdeon) generated from delivering such documents electronically will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings.

VII. eEOB SERVICE

- Payer shall provide Emdeon (in a manner specified by Emdeon) with a list of its Members (as defined above) who have elected to receive email notification that their EOB Claims Communications are available for online viewing ("eMembers"). Along with the list of its eMembers, Payer shall provide Emdeon with any other information necessary (as specified by Emdeon) for Emdeon to create such email notification.
- Utilizing the information provided by Payer, Emdeon shall create an email notification informing the eMembers that their EOB Claims Communications are available for viewing online. The email notification shall contain a hyperlink that will take the eMember to the Payer's website which will contain such eMember's EOB Claims Communication. This email notification shall be in lieu of mailing such eMembers EOB Claims Communication.

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VIII. ePAYMENT SERVICE

A. Description of ePayment Service if Parties utilize Payer's Bank to submit ACH Transactions to Providers:

1. Establishing the Originating Deposit Financial Institution (ODFI)

a. Payer shall select a bank or banks that will serve as the Originating Depository Financial Institution (the "ODFI") for the ACH Transactions (as that term is defined below).

i. The ODFI must be a Federal Deposit Insurance Corporation – insured financial institution with an established account and service relationship with the Federal Reserve Banks of the U.S. Federal Reserve System, and capable of executing Fedwire and FedACH transactions.

ii. The ODFI must be able to conduct automated clearing house (ACH) electronic payment transactions in the standard NACHA format.

iii. "ACH Transaction" shall mean any individual payment to an Enabled Entity (as that term is defined below) for which Emdeon shall send payment instructions to the ODFI and for which payment is made by the ODFI pursuant to such instructions, regardless of whether the payment is combined by the ODFI with any other payment to the Enabled Entity, the Enabled Entity's bank, or any correspondent of the Enabled Entity's bank or the payment is made simultaneously with any other payment by the ODFI.

b. Payer shall establish one or more accounts with the selected ODFI to fund the ACH Transactions (any such account being referred to herein as a "Designated Account"). Payer shall inform Emdeon in writing of the identity of the ODFI and of each Designated Account. Payer shall be solely responsible for fully funding and maintaining each such Designated Account.

c. Payer shall be solely responsible to pay any and all fees associated with selecting, establishing and maintaining the ODFI and each Designated Account as well as for any and all fees imposed by the ODFI or other third party associated with any ACH Transaction and for any and all overdraft charges.

d. Payer shall direct the ODFI to: (i) authorize Emdeon to initiate debit and credit ACH Transactions from each Designated Account on behalf of Payer (such authorization being referred to as "Transaction Authorization"), and (ii) notify Emdeon's Senior Vice President - Operations in writing when the ODFI has accepted the Transaction Authorization.

e. Promptly after receiving notification of the Transaction Authorization, Emdeon will coordinate with the ODFI to designate a mutually agreeable file transmission method through which Emdeon can initiate ACH Transactions from each Designated Account.

f. Emdeon shall notify Payer via email once the ACH file transmission method has been selected and fully tested with the ODFI.

g. Payer acknowledges and agrees that Emdeon shall not be responsible or liable for any claims, losses or damages (including any errors or delays in an ACH Transaction) that are attributable to or are caused by the acts or omissions of the ODFI or Payer.

2. *Enabled and Designated Entities*

a. Emdeon maintains a register (the "Register") of Providers (as defined above) that are enabled to receive payments from a Designated Account via ACH Transactions as provided in Section III below. Each such Provider shall be referred to herein as an "Enabled Entity."

b. In the event that Payer desires for Emdeon to add a new Provider (a "Designated Entity") into Emdeon's Register, Payer shall identify such Designated Entity to Emdeon in writing, providing Emdeon with sufficient contact information to allow Emdeon to enroll such Designated Entity in the ePayment Services. Payer shall reasonably assist Emdeon in obtaining all the necessary information from such Designated Entity to enable Emdeon to enroll such Designated Entity in the ePayment Services. The parties acknowledge and agree that such Designated Entity shall become an "Enabled Entity" only after it has completed all of the necessary enrollment and registrations procedures specified by Emdeon.

c. Payer acknowledges and agrees that Emdeon shall not be responsible or liable for any claims, losses or damages arising from Emdeon's actions or omissions in reliance on information provided by an Enabled Entity.

3. *ePayment Services*

With respect to each Enabled Entity, Emdeon shall provide the ePayment Services in the following manner:

a. Payer shall submit its Claims Communications data to Emdeon for processing utilizing the data file format and delivery method specified by Emdeon (the "Data Feed").

b. Utilizing the information contained within the Payer's Data Feed, Emdeon shall identify any Enabled Entities who are to receive payments from Payer. Utilizing the information contained in Payer's Data Feed, Emdeon shall create an ACH Transaction instruction in the standard NACHA format for each payment destined to an Enabled Entity. Provided the Data Feed contains all the information necessary (as specified by Emdeon) for Emdeon to create such an ACH Transaction, Emdeon shall submit such ACH Transaction instruction to Payer's ODFI for processing within two (2) business days after Payer authorizes the release thereof through the Data Feed, the Client Access System, or as otherwise specified by Emdeon, whichever shall first occur.

c. Emdeon shall notify Payer of all ACH Transactions via the file receipt process or other processes specified by Emdeon.

d. With respect to each ACH Transaction, Emdeon shall promptly notify Payer of any errors associated with the ACH file generation or transmission process within two (2) business days of Emdeon's knowledge of such error(s). Such notifications shall be delivered to Payer through email and/or through posting on Emdeon's Client Access System. Payer shall then either re-submit the files which contained such errors or cooperate with Emdeon, the ODFI, the Enabled Entity, and the Enabled Entity's bank in a manual process to correct or compensate for such errors.

B. Any savings (as calculated by Emdeon) achieved through the use of the ePayment Services shall be included when determining Healthpayers USA savings.

IX. USPS MAIL TRACKING SERVICE

USPS Mail Tracking Service allows Payer to utilize the Client Access System to track Payer's first class mail #10 envelopes, 6x9 envelopes and flat envelopes as they are processed through the USPS system.

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X. ERA SERVICE

A. Description of ERA Services if Payer is generating the ERA

- Payer shall create an Electronic Remittance Advice ("ERA") for each ERA that it desires to have sent through Emdeon's EDI network. Payer shall create such ERAs in the standard X12 835 version 4010 A1 format, in accordance with the X12 ERA Implementation Guide, containing all the necessary data elements. Once created, Payer shall forward such ERAs to Emdeon. Emdeon shall then make such ERAs available (through its EDI network and through its other products and services, including Emdeon's ERA Manager) to "Receivers" (as such term is defined below) who are authorized by Emdeon to access such ERAs.

- Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims that may arise from or are attributable to inaccuracies or errors in an ERA if such inaccuracies or errors arise from or attributable to Payer's failure to provide all of the necessary data or from incorrect data supplied by Payer or from Payer's failure to provide an ERA in the proper format.

- "Receivers" shall mean the entities, including, without limitation, direct receiving providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers who are authorized by Emdeon to receive transactions through the EDI network.

B. Description of ERA Services if Emdeon is generating the ERA from Payer's data file

- Emdeon shall create ERA transactions for Payer from the data supplied by Payer utilizing the data file format and delivery method specified by Emdeon. Emdeon shall create the ERA in accordance with the ERA specifications published by Emdeon in effect, from time to time, including the ERA Data Map and the ERA Code Crosswalk (the "ERA Specifications"). Emdeon shall make such ERAs available (through its EDI network and through its other products and services, including Emdeon's ERA Manager) to "Receivers" (as such term is defined above) who are authorized by Emdeon to access such ERAs.

- Payer agrees to supply Emdeon with all of the data necessary to create an ERA transaction in accordance with the ERA Specifications. Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims that may arise from or are attributable to inaccuracies or errors in an ERA if such inaccuracies or errors arise from or are attributable to Payer's failure to provide all of the necessary data or from incorrect data supplied by Payer. In addition, Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims relating to any ERA transactions that was created in accordance with the ERA Specifications, including the ERA Data Map and ERA Code Crosswalk.

XI. TERRORIST WATCH SERVICE

The Terrorist Watch Service monitors Payer's payments to ensure payments are not being sent to individuals on the OFAC Blocked Persons List. The Terrorist Watch Service is defined below:

- Emdeon shall maintain a database table containing the names and addresses of known and suspected terrorists ("Suspected Individual Database"). Emdeon shall update the Suspected Individual Database at a minimum of once per month. The information used to create and update the Suspected Individual Database shall be derived exclusively from the official United States Government website, http://www.ustreas.gov/offices/eotffc/ofac (the "Government Website"). Emdeon makes no representations or warranties as to the accuracy or sufficiency of the information contained on the Government Website.

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- Emdeon shall analyze and compare all check documents sent by Payer to Emdeon for a match in the Suspected Individual Database. The matching logic will verify the name and address of the check document against the names and addresses listed Suspected Individual Database.
- Any check document identified as a match will be rerouted to Payer and coded with a special mail handling code of "TW".

XII. REPORTS

Emdeon provides Standard Reports via hardcopy, email, and CAS at no additional cost. Payer can also request Custom Reports for an additional charge to the Payer. Standard Reports are defined below.

Required Reports:

- Emdeon File Receipt Confirmation/Check Summary Report – via email.
- Emdeon Monthly Invoice – Itemized by group and delivered via hardcopy and email.
- Emdeon CAS provides a series of process and delivery audit reports.

XIII. HOLIDAYS

Emdeon's holidays are listed below. The Emdeon production and client services department are closed on these dates.

New Year's Day
Memorial Day
July 4th
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Day

If any of the Holidays falls on a weekend, the Friday before the Holiday or the Monday after the Holiday will be observed. Holiday observation dates can be provided upon request.

XIV. CONTACT LIST

[PAYER NAME] Contacts

Contact 1:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____
Contact 2:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____
Contact 3:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____

Emdeon Contacts

Contact 1:	NAME	Lynn McKeone
	PHONE #	314-785-4301
	FAX#	314-770-2654
	Email	lmckeone@emdeon.com

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Contact 2:	NAME	Pat Coughlin
	PHONE #	314-785-4300
	FAX#	314-770-2654
	Email	pcoughlin@emdeon.com
Contact 3:	NAME	Jeff Mouser
	PHONE #	314-785-4302
	FAX#	314-770-2654
	Email	jmouser@emdeon.com

XV. AUTHORIZATION FORM

Payer must provide written confirmation of its intent to go into live production by providing Emdeon, either via hard copy or e-mail, an authorization form that is substantially similar to the example below. The Emdeon Implementation Manager will initiate this process, once testing is completed.

By my signature affixed below, I certify that I have reviewed the results of the parallel tests conducted by Emdeon pursuant to that certain Emdeon Business Services Payer Agreement dated as of _____, 20__ and, as an authorized agent of [PAYER NAME], hereby authorize Emdeon to immediately commence the CPCS Services, as defined in the Emdeon Business Services Payer Agreement. The official start date shall be _____, 20__.

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ADDENDUM NO. 2 TO
CONTRACT MC 04123

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA
(CalOptima)

AND

ENVOY LLC
(Contractor)

ADDENDUM NO. 2 TO THIS CONTRACT is entered into as of this 25th day of January, 2017, with respect to the following facts:

A. CalOptima and Contractor (hereinafter collectively referred to as the "**Parties**") entered into the Emdeon Payer Agreement (Contract MC 04123) effective September 1, 2011, for Emdeon E-Services and Emdeon Claims Payment and Communication Services (hereinafter, "**Contract**").

B. Pursuant to –Section 3.H.8. - Amendment of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The parties acknowledge and agree that on January 1, 2016, Envoy LLC changed its name to Change Healthcare Solutions, LLC. Therefore, all references to "**Envoy LLC**" under the Agreement shall be changed to "**Change Healthcare Solutions, LLC**" and all references to the defined term "**Emdeon**" shall be changed to "**CHC**" or "**Change Healthcare.**"

3. **No Other Changes.** This Addendum No. 2 is by this reference made part of said Contract. Except as otherwise provided in this Addendum, all of the terms, conditions, and provisions of the Contract and prior addendums shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Addendum and any provisions of the Contract and prior addendums, if any, the provisions of this Addendum No. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Addendum shall have the same meaning as ascribed to them in the Addendum. The execution and delivery of this Addendum shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Addendum shall not operate as a waiver of or, except as expressly set forth herein, an addendum of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Addendum No. 2 on the day and year last shown below.

"OCALOPTIMA"

Date: _____

By: ~~Chet Uma~~ Mark Finch
Its: ~~Chief Financial Officer~~ Procurement Manager

Date: _____

By: ~~Michael Schnader~~
Its: ~~Chief Executive Officer~~

Date: January 25, 2017

Change Healthcare Solutions, LLC

By: Daniel E. Cortez
Its: VP and Senior Managing Division Counsel

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ORIGINAL

DATA CLEARINGHOUSE AGREEMENT

This Data Clearinghouse Agreement (the "Agreement") is entered into as of July 1, 2004 (the "Effective Date") by and between CalOptima, a public agency in the State of California, ("CalOptima") and Office Ally, L.L.C., a California corporation having its principal place of business at 1107 S. Coast Highway, Laguna Beach, CA 92651 ("Vendor").

RECITALS

A. CalOptima desires to purchase and acquire from Vendor certain services (the "Services") relating to the creation of a clearinghouse for CalOptima's data, as more fully described in Exhibit A hereto.

B. Vendor desires to sell and provide such Services to CalOptima, all in accordance with the terms and conditions of this Agreement. Vendor has represented that it has the systems architecture, professional skills, and technological capabilities required to fulfill its obligations hereunder.

NOW, THEREFORE, in consideration of the foregoing Recitals (which are incorporated herein) and other good and valuable consideration, the parties agree as follows:

AGREEMENT

1. ARTICLE I – DOCUMENTS CONSTITUTING CONTRACT

This Agreement shall include, in addition to this document and its exhibits and attachments, all documents cited herein or incorporated by reference. The invalidity in whole or in part of any term or condition of the Agreement shall not affect the validity of other terms or conditions. CalOptima's failure to insist on any one or more instances upon Vendor's performance of such terms or conditions of this Agreement shall not be construed as a waiver or relinquishment of CalOptima's right to such performance or to future performance of such terms or conditions, and Vendor's obligation in respect thereto shall continue in full force and effect. In the event of any conflict of provisions among the documents constituting the Agreement, the provisions shall prevail in the following descending order of precedence: (1) the provisions of this Agreement, including all exhibits and attachments; and (2) all other documents cited herein or incorporated by reference.

2. SERVICES AND SPECIFICATIONS.

(a) Vendor agrees to perform those services and duties as set forth in Exhibit A; all other performance requirements included or incorporated by reference into this Agreement; and, to the extent it is not inconsistent with the above, the documentation

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delivered to CalOptima by Vendor hereunder (collectively, the "Specifications"). Vendor shall provide appropriate personnel to timely and professionally perform its obligations hereunder. CalOptima and Vendor may amend Exhibit A (or attach additional Exhibits A sequentially numbered as Exhibit A-1, Exhibit A-2, and so on) from time to time by mutual written agreement.

(b) Vendor shall use security measures in accordance with industry best practices to prevent unauthorized intrusions and access into its systems and data. Vendor, however, cannot guarantee or warrant that such intrusions and access will not occur despite its best efforts, unless such intrusions and access result from Vendor's negligence or willful misconduct.

(c) CalOptima assumes all responsibility for the data supplied by CalOptima to Vendor, and Vendor shall have no liability of any kind with regard to CalOptima's use of CalOptima's own data. Vendor will correct any material errors in the output it furnishes to CalOptima if the error results from defects in the programs or services provided by Vendor within fifteen (15) days of CalOptima's receipt of the first output that evidences the error.

3. ACCEPTANCE TESTING.

Prior to first productive use of the Services in CalOptima's day-to-day operations, Vendor shall notify CalOptima that the Services are ready to be tested for conformance to the Specifications. CalOptima will test or evaluate the Services to determine whether they conform in all material respects with the Specifications. Upon completion of review and testing, CalOptima shall promptly notify Vendor whether it has accepted the Services ("Accept"), or whether it has identified discrepancies with the Specifications ("Reject"). CalOptima may Accept or Reject the Services in its sole discretion. If CalOptima Rejects the Services, CalOptima shall provide a written list of items that must be corrected. On receipt of CalOptima's notice, Vendor shall immediately commence all reasonable efforts to complete, as quickly as possible, such necessary corrections, repairs and modifications to the Services as will permit them to be ready for retesting and review, but in no event shall such corrective measures exceed twenty (20) days. The testing and evaluation process shall resume, as set forth above. If CalOptima Accepts the Services, it shall issue a written "Acceptance Notice." The date of such Acceptance Notice shall be deemed the "Acceptance Date." If CalOptima determines that the Services, as revised, still do not comply in all material respects with the Specifications, CalOptima may either (1) afford Vendor the opportunity to repeat the correction and modification process as set forth above, or (2) depending on the nature and extent of the failure in CalOptima's sole judgment, terminate this Agreement in accordance with Section 5 (Term and Termination) as a non-curable default. The foregoing correction and modification procedure shall be repeated until the Services, based on CalOptima's good faith determination, conform to the Specifications, or CalOptima elects one of the termination options described above.

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4. PRICES AND PAYMENT TERMS.

(a) Fee Schedule. CalOptima will pay Vendor in accordance with the fee schedule attached hereto as Exhibit B ("Fee Schedule"). Vendor will be solely responsible for payment of all sales, use, or other taxes assessed against or associated with the Services or any other service authorized by CalOptima under this Agreement.

(b) Compensation and Expense Reimbursement. Apart from any expenses expressly specified in the Fee Schedule as reimbursable, Vendor will be responsible for all costs and expenses incidental to the performance of Services for CalOptima hereunder, including but not limited to, all costs of licenses, bonds or taxes required of or imposed against Vendor and all other of Vendor's costs of doing business. In addition, no payments will be made for services rendered by Vendor other than the Services, unless such services are approved in advance in writing by CalOptima.

(c) Invoices. Vendor may invoice CalOptima on a monthly basis for chargeable services provided. The rates, as defined in Exhibit B, Fee Schedule, are acknowledged to include Vendor's base labor rates, overhead and profit. Work completed shall be documented on Vendor's invoice(s). Vendor shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as Vendor has documented, to CalOptima's satisfaction, that Vendor has fully completed the work required under this Agreement and Vendor's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of Vendor's work under this Agreement.

(d) Vendor shall submit invoices to CalOptima's Accounts Payable Office. Each invoice shall provide the description of work performed; the time period covered by the invoice and the amount of payment requested. CalOptima shall remit payment within thirty (30) days of receipt of each invoice, provided that CalOptima does not timely and reasonably dispute such invoice. CalOptima's dispute of specific charges on any part of an invoice does not relieve CalOptima of responsibility to pay the undisputed portion on the due date. Undisputed unpaid balances shall bear interest charges of one and one-half percent (1.5%) per month or fraction thereof.

5. TERM AND TERMINATION.

(a) Term. This Agreement will commence on the Effective Date and will remain in effect for an initial term of one (1) year(s) (the "Initial Term"), unless earlier terminated in accordance with the provisions of this Agreement. At the end of the Initial Term, CalOptima may renew this Agreement for three (3) successive periods of one (1) year (each a "Renewal Term") by written notice to Vendor not less than thirty (30) days prior to the end of the then-current term. If written notice is not provided, this Agreement shall terminate at the end of the then-current Renewal Term. As used herein, "Term" shall mean the Initial Term and any Renewal Terms.

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(b) Termination for Unavailability of Funds.

In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Agreement as follows:

i. Right to Terminate. CalOptima may terminate this Agreement if it does not receive funding from the State of California for any fiscal year.

ii. Payment of Fees. If this Agreement is terminated pursuant to this Section 5 (Term and Termination), CalOptima agrees to promptly pay Vendor all fees and other charges due and payable as of the termination date.

iii. Reinstatement. If this Agreement is terminated pursuant to this Section 5 (Term and Termination) and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify Vendor in writing and CalOptima shall have the right to reinstate this Agreement for that period for which funds are received by CalOptima or the unexpired term of this Agreement as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Agreement two (2) times during the Term of this Agreement.

(c) Termination for Convenience by CalOptima. CalOptima may terminate this Agreement without any breach by Vendor by providing written notice to Vendor sixty (60) days in advance of the effective date of termination. Upon such termination, CalOptima will be responsible for payment of undisputed fees for Services rendered prior to the effective date of such termination.

(d) Automatic Termination. This Agreement shall terminate automatically if CalOptima's Agreement with the State of California is terminated. This Agreement shall also automatically terminate if the Department of Health Services (DHS) withdraws its approval of waiver granted under Section 1915(b) of the Social Security Act for county-wide organization health systems.

(e) Termination for Cause. Either party may terminate this Agreement upon thirty (30) days written notice to the other party as a result of any of the following events:

i. A material breach of this Agreement, provided that such breach has not been cured by the expiration of such thirty (30) day period.

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ii. Either party becomes insolvent, makes a general assignment for the benefit of creditors, seeks protection under any bankruptcy laws or consents to or acquires any trustee, receiver or the other person authorized to take over the business operations and/or assets of such party.

iii. Nonpayment of any undisputed invoice amount.

6. OUTSOURCING AND ASSIGNMENT.

(a) Vendor. Vendor's obligations are personal to Vendor, and Vendor acknowledges that CalOptima has entered this Agreement in reliance on Vendor's ability and agreement to perform its obligations accurately, competently and completely. Vendor may not outsource, assign, subcontract or delegate this Agreement nor any of its rights, duties or obligations under this Agreement without the express written consent of CalOptima. Any purported assignment or delegation in violation of this provision shall be void at the option of CalOptima. CalOptima's consent shall not be deemed an endorsement of such assignment or delegation and shall not relieve Vendor of any of its obligations or liabilities under this Agreement. Any such assignment, delegation or subcontracting, even if approved by CalOptima, will be at Vendor's own risk and expense.

(b) CalOptima. CalOptima reserves the right to assign its rights and obligations hereunder, as it deems appropriate with the consent of Vendor, which consent shall not be unreasonably withheld.

7. WARRANTIES; LIMITS OF LIABILITY.

(a) Standard of Performance. Vendor warrants to CalOptima that it will perform the Services in accordance with (i) the Specifications and (ii) in accordance with generally accepted professional standards for similar services in effect at the time of such performance. Without limiting the foregoing, Vendor will provide prompt and professional responses to all CalOptima requests.

(b) Intellectual Property Warranty. Vendor warrants that Vendor will not, in its provision of Services, infringe or misappropriate any patent, copyright, trade name, trade secret or other proprietary right (collectively "Intellectual Property Rights") of a third party. If any Service or part thereof furnished under this Agreement, becomes, or in CalOptima's or Vendor's reasonable opinion is likely to become, the subject of any claim arising from or alleging infringement of, or in the event of any adjudication that such Service or part thereof infringes on, any Intellectual Property Right of a third party, Vendor, at its own expense shall take the following actions in the listed order of preference:

i. secure for CalOptima the right to continue using the Service and/or part thereof;

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ii. replace or modify the Service and/or part thereof to make it non-infringing; provided, however, that such modification or replacement shall not degrade the operation or performance of the Service; or

iii. refund all fees paid by CalOptima to Vendor hereunder.

(c) Rights to Perform. Vendor further represents and warrants, during the entire term of this Agreement, (i) that Vendor has and will have all rights, titles, licenses, permissions, and approvals necessary to perform its obligations hereunder, to provide the Services to CalOptima as contemplated by this Agreement and to grant CalOptima the rights granted herein, and (ii) there are no claims, demands or proceedings that have been instituted, or are pending or threatened, by any person against Vendor or, to Vendor's knowledge, any customer of Vendor alleging any matter contrary to the foregoing.

(d) Disabling Device. Vendor represents, warrants and agrees that Vendor will not knowingly cause any unplanned interruption of the operations of, or accessibility to the Services through any device, method or means including, without limitation, the use of any "virus," "lockup," "time bomb," or "key lock" device or program, or disabling code, which has the potential or capability of causing any unplanned interruption of the operations of, or accessibility of the Services, to CalOptima or any authorized user or which could alter, destroy, or inhibit the use of the Services, or any data contained therein or accessible thereby (collectively referred to for purposes of this Section as "Disabling Device(s)") which could block access to or prevent the use of the Services or data by CalOptima or any of CalOptima's or authorized users.

(e) Insurance. Vendor represents, warrants and agrees that it has in place, and will maintain in full force and effect throughout the Term, all insurance policies in accordance with Section 12 below and industry standards.

(f) Assignment of Warranties. To the extent permissible, Vendor hereby assigns and agrees to deliver to CalOptima all representations and warranties received by Vendor from Vendor's third party licensors or suppliers.

(g) Warranty Disclaimer. Except for the representations and warranties set forth in this Agreement (including the Exhibits attached hereto), neither party makes any warranties of any kind, whether express, implied or statutory, including any warranties of merchantability, noninfringement of third party rights or fitness for a particular purpose, which are hereby expressly disclaimed.

(h) Overall Liability. EXCEPT FOR VENDOR'S INDEMNIFICATION OBLIGATIONS HEREUNDER OR WITH RESPECT TO A BREACH OF SECTION 8 (CONFIDENTIAL INFORMATION), NEITHER PARTY'S TOTAL LIABILITY TO THE OTHER PARTY FOR ANY CLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT SHALL EXCEED THE GREATER OF (i) $50,000 OR (ii) THE AMOUNT OF ALL MONIES PAID BY CALOPTIMA TO VENDOR DURING THE

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TWELVE MONTHS PRIOR TO THE DATE SUCH CLAIM AROSE, OR PROJECTION OF TWELVE MONTH PERIOD, IF THE EVENT RESULTING IN LIABILITY OCCURS BEFORE TWELVE MONTHS OF HISTORY EXISTS.

(i) Indirect Damages. EXCEPT FOR VENDOR'S INDEMNIFICATION OBLIGATIONS HEREUNDER OR WITH RESPECT TO A BREACH OF SECTION 8 (CONFIDENTIAL INFORMATION), NEITHER PARTY SHALL HAVE ANY LIABILITY TO THE OTHER OR ANY THIRD PARTY FOR ANY INCIDENTAL, INDIRECT, CONSEQUENTIAL, PUNITIVE, OR SPECIAL DAMAGES OF ANY KIND (INCLUDING LOST REVENUES OR PROFITS, LOSS OF BUSINESS, OR LOSS OF DATA) ARISING OUT OF OR IN CONNECTION WITH OR RELATED TO THIS AGREEMENT OR THE RIGHTS PROVIDED HEREUNDER SUFFERED BY A PARTY OR BY ANY ASSIGNEE, TRANSFEREE OF, OR THIRD PARTY CLAIMING RIGHTS DERIVED FROM A PARTY TO THIS AGREEMENT, EVEN IF INFORMED IN ADVANCE OF THE POSSIBILITY OF SUCH DAMAGES.

8. CONFIDENTIAL INFORMATION.

(a) Definition of Confidential Information. For purposes hereof, "Confidential Information" shall mean, collectively: (i) regardless of whether marked confidential or proprietary, any information relating to patients of CalOptima or any other health care provider, any information concerning research activities and plans, marketing or sales plans, pricing or pricing strategies, operational techniques, strategic plans, financial information, business opportunities, personnel information, research, development or know-how; (ii) any information designated by either party as "confidential" or "proprietary" or which, under the circumstances taken as a whole, would reasonably be deemed to be confidential; and (iii) the terms and conditions of this Agreement.

(b) Exclusions. Notwithstanding the foregoing, Confidential Information will not include any information or material to the extent any such information or material that:

i. is or becomes public information, unless such publication is a breach of this Agreement or a similar confidentiality or non-disclosure agreement;

ii. was already known to the disclosing party prior to being disclosed by or obtained from the other party as evidenced by written records kept in the ordinary course of business of or by proof of actual use by the disclosing party;

iii. has been or is hereafter rightfully received by the disclosing party from a third person (other than the other party) without restriction or disclosure and without breach of this Agreement; or

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iv. has been independently developed by the disclosing party without reference to the other party's Confidential Information.

It will be presumed that any Confidential Information in a disclosing party's possession is not within exception (b) above, and the burden will be upon the disclosing party to prove otherwise by records and documentation.

(c) Treatment of Confidential Information. Each party recognizes the importance of the other's Confidential Information. In particular, each party recognizes and agrees that the Confidential Information of the other is critical to their respective businesses and that neither party would enter into this Agreement without assurance that such information and the value thereof will be protected as provided in this Section 8 and elsewhere in this Agreement. Accordingly, each party agrees as follows:

i. Each party will hold any and all Confidential Information it obtains in strictest confidence and will use and permit use of Confidential Information solely for the purposes of this Agreement.

ii. Each party may disclose or provide access to its responsible employees, and may make copies, of Confidential Information only to the extent reasonably necessary to carry out its duties hereunder.

iii. Each party currently has, and in the future will maintain in effect and enforce, rules and policies to protect against access to or use or disclosure of Confidential Information other than in accordance with this Agreement, including without limitation written instruction to and agreements with employees and agents to ensure that such employees and agents protect the confidentiality of Confidential Information. Each party expressly will instruct its employees and agents not to disclose Confidential Information to third parties, including without limitation customers, subcontractors or consultants, without the other's prior written consent.

iv. Each party, at its own expense, will take all steps, including without limitation the initiation and prosecution of actions at law or in equity, necessary or appropriate to prevent use or disclosure, and upon any unauthorized disclosure further unauthorized disclosure or use, of any Confidential Information received or obtained by it except as expressly permitted by the terms of this Agreement.

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v. Each party will notify the other immediately of any unauthorized disclosure or use, and will cooperate with that party to protect all proprietary rights in and ownership of its Confidential Information.

(d) Compelled Disclosures. To the extent required by applicable law or by lawful order or requirement of a court or governmental authority having competent jurisdiction over the disclosing party, the disclosing party may disclose Confidential Information, in accordance with such law or order or requirement, subject to the following conditions: As soon as possible after becoming aware of such law, order or requirement and prior to disclosing Confidential Information, pursuant thereto, the disclosing party will so notify the other party in writing and, if possible, the disclosing party will provide the other party notice not less than five (5) business days prior to the required disclosure. The disclosing party will use reasonable efforts not to release Confidential Information, pending the outcome of any measures taken by the other party to contest, otherwise oppose or seek to limit such disclosure by the disclosing party and any subsequent disclosure or use of Confidential Information, that may result from such disclosure. The disclosing party will cooperate with the other party regarding such measures. Notwithstanding any such disclosure, the disclosing party will not affect its obligations hereunder with respect to Confidential Information so disclosed.

(e) Disclosures to Contractors. Subject to Section 6(a), above, Vendor may use independent contractors who are natural persons in fulfilling its duties under this Agreement provided that Vendor will be responsible and liable for such independent contractors and will obtain confidentiality agreements from such independent contractors. Such confidentiality agreements must contain: (i) provisions which require that the independent contractor comply with the terms and conditions of this Section 8; and (ii) language providing that CalOptima may enforce its rights against the independent contractor as an intended third party beneficiary of such agreement, even though CalOptima is not a party to such agreement, provided that CalOptima's right to exercise such rights will be conditioned on its having given Vendor reasonable prior written notice of CalOptima's intention to do so, and specific reasons for doing so, such that Vendor has a reasonable opportunity to resolve the issue that CalOptima has with such independent contractor. Vendor will provide CalOptima with copies of such confidentiality agreements upon request.

(f) Return of Confidential Information. Upon the disclosing party's written request or upon expiration or termination of this Agreement for any reason, the receiving party will promptly return or destroy, at the disclosing party's option, all originals and copies of all Confidential Information, all originals and copies of all summaries, records, descriptions, modifications, negatives, drawings, adoptions and other documents or materials, whether in writing or in machine-readable form, prepared by receiving party prepared under its direction or at its request from the Confidential Information.

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(g) Non-Exclusive Equitable Remedy. Each party acknowledges and agrees that due to the unique nature of Confidential Information, there can be no adequate remedy at law for any breach of its obligations hereunder, that any such breach will result in irreparable harm to such party, and therefore, that upon any such breach or any threat thereof, each party will be entitled to appropriate equitable relief from a court of competent jurisdiction in addition to whatever remedies either of them might have with this Agreement and to be indemnified by the other party from any loss or harm, including, without limitation, lost profits and attorneys' fees, in connection with any breach or enforcement of such party's obligations hereunder or the unauthorized use or release of any such Confidential Information. Each party will notify the other in writing immediately upon the occurrence of any such unauthorized release or other breach. Any breach of this Section 8 will constitute a material breach of this Agreement and be grounds for immediate termination of this Agreement in the exclusive discretion of the non-breaching party.

(h) Security of Patient Information. Without limiting the foregoing, Vendor will maintain and enforce safety and physical security procedures with respect to its access and maintenance of any and all information relating to patients that are (i) at least equal to industry standards for such types of locations, (ii) in accordance with CalOptima's provided security requirements, and (iii) which are in compliance with all Federal, State and local laws, rule and regulations. The term, "applicable Federal, State, and local laws" above, specifically includes, without limitation, the following:

i. Applicable provisions (Sections 261-264) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all implementing regulations from the Department of Health and Human Services, whether such regulations are proposed or finally adopted (each set of proposed implementing regulations shall be considered replaced, for purposes of this Agreement, by their final implementing regulations at the time the final implementing regulations are published), including without limitation the implementing regulations entitled, "Standards for Privacy of Individually Identifiable Health Information" and "Security and Electronic Standards" (altogether, the "HIPAA Requirements");

ii. Applicable requirements of the Food and Drug Administration ("FDA"), including without limitation the requirements of 21 Code of Federal Regulations ("C.F.R.") Part 11 (entitled "Electronic Records; Electronic Signatures"); the "Guidance for Industry" published in April, 1999 by the FDA entitled, "Computerized Systems Used In Clinical Trials;" and any required FDA approval or certification any System Component; and

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iii. Applicable Hospital Conditions of Participation for the Medicare and Medicaid Programs that require protection of and security for health information and appropriate patient access to such information, including without limitation 42 C.F.R. Section 482.13 (d) (entitled "Standard: Confidentiality of Patient Records").

9. BUSINESS ASSOCIATE AGREEMENT

Vendor agrees to sign a Business Associate Agreement, which is attached hereto as Exhibit C and incorporated herein by this reference

10. INDEMNIFICATION.

(a) Indemnification. Vendor will indemnify and hold harmless CalOptima, its affiliates, successors and assigns and the directors, officers and employees and agents of any of them (each an "Indemnified Party"), from any claim, loss, damage, expense or liability arising out of (i) a breach by Vendor of Section 8 (Confidential Information); (ii) a claim that CalOptima's permitted use of the Services and Software infringes the patent, copyright, trade secret, or other rights of a third party; or (iii) arising out of or incurred by any such person due to the negligence or willful misconduct of Vendor or its directors, officers or employees, except to the extent arising out of or based on any negligent act or omission of CalOptima with respect to the subject matter of this Agreement.

(b) Indemnification Procedure. CalOptima will as soon as is reasonably practicable provide Vendor with prompt written notice of any claim for which indemnification is required, tender the defense of any such claim to Vendor, provide reasonable cooperation for such defense at Vendor's expense, and not settle without Vendor's prior written approval, not to be unreasonably withheld. CalOptima may participate in any such defense or settlement with counsel of its own choosing at its expense.

11. INDEPENDENT CONTRACTOR STATUS.

The parties acknowledge that neither Vendor nor Vendor's employees or agents are CalOptima employees for state or federal tax purposes or any other purpose. As neither Vendor nor Vendor's employees or agents are CalOptima's employee, Vendor is responsible for paying all required state and federal taxes or other amounts due as a result of the payment of compensation by CalOptima under this Agreement. In particular: (i) CalOptima will not withhold FICA from Vendor's payments; (ii) CalOptima will not make state or federal unemployment insurance contributions on behalf of Vendor, its employees or agents; (iii) CalOptima will not withhold state or federal income tax from the payments to Vendor; (iv) CalOptima will not make disability insurance contributions on behalf of Vendor, its employees or agents; and (v) CalOptima will not obtain workers' compensation insurance on behalf of Vendor, its employees or agents. However,

CalOptima may, at its sole discretion, report its payments to Vendor to appropriate state and federal government agencies.

12. INSURANCE REQUIREMENTS.

(a) Required Insurance Coverages. Vendor shall obtain, pay for, and maintain in full force and effect during the Term insurance as follows:

i. Workers' compensation and employers' liability insurance with limits to conform with the greater of the amount required by California law or one million dollars ($1,000,000) each accident, including occupational disease coverage;

ii. Commercial general liability insurance with limits not less than three million dollars ($3,000,000) combined single limit for bodily injury, death, and property damage, including personal injury, contractual liability, independent contractors, broad-form property damage, and products and completed operations coverage;

iii. Commercial automobile liability insurance with limits not less than one million dollars ($1,000,000) each occurrence combined single limit of liability for bodily injury, death, and property damage, including owned and non-owned and hired automobile coverages, as applicable; and

iv. Professional liability insurance (Errors and Omissions) with limits not less than three million dollars ($3,000,000) annual aggregate for all claims each policy year for computer programming and electronic data processing services.

(b) Claims Made Coverages. To the extent any insurance coverage required under this Section is purchased on a "claims-made" basis, such insurance shall cover all prior acts of Vendor during the Term, and such insurance shall be continuously maintained until at least three (3) years beyond the expiration or termination of the Term, or Vendor shall purchase "tail" coverage, effective upon termination of any such policy or upon termination or expiration of the Term, to provide coverage for at least one (1) year from the occurrence of either such event.

(c) Certificates Of Insurance. Certificates of Insurance evidencing all coverages described in this Section shall be furnished to CalOptima prior to the Effective Date.

(d) Cancellation Or Lapse Of Insurance. Vendor shall give thirty (30) days' prior written notice to CalOptima of cancellation, non-renewal, or material change in coverage, scope, or amount of any policy. Should Vendor fail to keep in effect at all times the insurance coverages required under this Section 12, CalOptima may, in addition

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to and cumulative with any other remedies available at law, equity, or hereunder withhold payments to Vendor required under this Agreement in an amount sufficient to procure the insurance required herein.

13. VERIFICATION OF CALOPTIMA COSTS BY GOVERNMENT.

Until the expiration of eight (8) years after the furnishing of any service pursuant to this Contract, Vendor will make available, upon written request of the Secretary of Health and Human Services of the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Services, Department of Justice, or Bureau of Medical Fraud, copies of this Agreement and any books, documents, records, and other data of Vendor that are necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership.

14. GENERAL.

(a) Compliance With Applicable Law. Vendor warrants that, in the performance of this Agreement, it shall observe and comply with federal, state, and local laws in effect when this Agreement is signed or which may come into effect during the term of this Agreement.

(b) Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of California, without giving effect to principles of conflicts of law.

(c) CalOptima Designee. The Chief Executive Officer of CalOptima, or their designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Agreement, subsequent to and in accordance with the authority granted by the Board of Directors.

(d) Prohibited Interests. Vendor covenants that, for the term of this Agreement, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Agreement or the proceeds thereof.

(e) Ownership Of Reports And Documents. The originals of all letters, documents, reports, software programs and other products and data produced for the purposes of this Agreement shall be delivered to, and become the property of CalOptima. Copies may be made for Vendor's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima.

(f) Notice of Labor Disputes. Whenever Vendor has knowledge that any actual or potential labor dispute may delay this Agreement, Vendor shall immediately notify and submit all relevant information to CalOptima. Vendor shall insert the

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substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Agreement.

(g) Unavoidable Delays. If the delivery of services under this Agreement should be unavoidably delayed, CalOptima, shall extend the time for completion of the Agreement for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during Vendor's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of Vendor, Vendor's subcontractors, or their agents, and was substantial and in fact caused Vendor to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays beyond the control of Vendor or caused by CalOptima will be sufficient justification for delay of services, and Vendor shall be allowed a day-for-day extension.

Vendor shall notify CalOptima, as soon as Vendor has, or should have, knowledge that an event has occurred which will delay deliveries. Within five (5) working days, Vendor shall confirm such notice in writing, furnishing as much detail as is available.

Vendor agrees to supply, as soon as such data are available, any reasonable proofs that are required by CalOptima, to make a decision on any request for extension. CalOptima shall examine the request and any documents supplied by Vendor and shall determine if Vendor is entitled to an extension and the duration of such extension. CalOptima shall notify Vendor of this decision in writing. It is expressly understood and agreed that Vendor shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

(h) Force Majuere. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Agreement during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

(i) No Liability Of County Of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

(j) Severability. The invalidity in whole or in part of any provision of this Agreement shall not affect the validity of other provisions.

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(k) Nonexclusive Agreement. This Agreement is a nonexclusive agreement. CalOptima expressly reserves the right to contract with others for any of the products or services it may require.

(l) Waiver. CalOptima's failure to insist on performance of any provision of this Agreement, or to exercise any right herein conferred, will not be construed as a waiver of CalOptima's right to assert or rely on that provision or right, or any similar provision or right, in any later instance.

(m)Notices. All notices, consents and other communications required by or permitted to be given under this Agreement will be in writing and will be deemed to have been duly given if and when: (i) delivered personally; (ii) sent by confirmed facsimile transmission; (iii) mailed by first class certified mail, return receipt requested, postage prepaid; or (iv) sent by a nationally recognized express courier service, postage or delivery charges prepaid, and in all events will be deemed given upon receipt. All such notices, consents and communications will be sent to the addresses set forth below, or to such other address as may be designated by a party by giving written notice to the other party pursuant to this Section.

To CalOptima:
CalOptima
1120 West La Veta Avenue
Orange, CA 92868
Attention: Bill Farry
Chief Information Officer

To Vendor:
Office Ally
1107 S. Coast Hwy.
Laguna Beach, CA 92651
Attn: Brian P. O'Neill

(n) Advertising. Vendor shall acquire no right to use, and shall not use, without CalOptima's prior written consent, the terms or existence of this Agreement, the names, characters, artwork, designs, trade names, copyrighted materials, trademarks or service marks of CalOptima, its related or subsidiary companies, parent, employees, directors, shareholders, assigns, successors or licensees: (i) in any advertising, publicity, press release, client list, presentation or promotion; (ii) to express or to imply any endorsement of Vendor or Vendor's services; or (iii) in any manner other than expressly in accordance with this Agreement.

(o) Entire Agreement. This Agreement and its Exhibits constitute the entire agreement between the parties regarding its subject matter, and supersede any prior or contemporaneous representations, understandings and agreements, whether oral or

written regarding its subject matter. This Agreement may be modified or amended only by a writing signed by duly authorized representatives of both parties. In the event of any conflict between thee terms of this Agreement and any Exhibit, attachment, work order, purchase order or other document between the parties, the body of this Agreement shall prevail and govern, with precedents next given to the Exhibits attached hereto.

(p) Survival. The following provisions will survive termination of this Agreement: 7, 8, 10, 11, 12(b), 13 and 14.

(q) Legal Fees. If any enforcement action or equitable claim between the parties with respect to this Agreement, the prevailing party in such proceeding will be entitled to receive its reasonable attorneys' fees, expert witness fees and out-of-pocket costs incurred in connection with such proceeding, in addition to any other relief it may be awarded.

No action, regardless of form, arising out of this Agreement may be brought by either party more than two (2) years after the cause of action has occurred, except an action for nonpayment may be brought within two (2) years of the date of the last payment.

IN WITNESS WHEREOF, duly authorized representatives of the parties have executed this Agreement as of the Effective Date.

CalOptima

By: _____

Title: CFO

VENDOR

By: _____

Title: President/CEO

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EXHIBIT A

SCOPE OF SERVICES

1. Objective

   To allow providers to submit claims data electronically in multiple formats to Vendor who in turn will apply approved edits and data validation and translate data into an ANSI 837 data file for submission to CalOptima.

2. Go-Live Requirements:

   a. Vendor shall have the ability to accept multiple file formats from Providers for HCFA1500 and UB92 claims and then convert them to ANSI 837 (through Level 4 compliance per Claredi).
   b. Vendor to stay current with HIPAA / ANSI regulation addends and changes.
   c. As needed to reflect changes in Medi-Cal billing and payment practices, additional business edits to be implemented in line with an agreed to timeline.
   d. FTP file transmission to CalOptima's FTP secure site with PGP encryption
   e. Vendor shall submit to CalOptima a daily file for each form type. (HCFA 1500, UB92 – split between inpatient and outpatient file, develop process to take 25-1 inbound LTC file layouts and convert to 837 ANSI format).
   f. Vendor shall accommodate "start-up" activities with CalOptima as follows:
      - Along with CalOptima, develop a standard letter of notification to the Provider community regarding CalOptima's ability to accept claims data electronically.
      - Mail the notification letter to each Provider on the list of Providers supplied by CalOptima.
      - Develop the test script program to download file(s) to CalOptima.
      - Incorporate business rules as defined by CalOptima into existing software code including but not limited to provider validation, member eligibility validation and claims processing rules.
        - CalOptima will provide Vendor with a weekly Provider Master file to support validation / business rule logic.
        - Source data for membership validation to be determined by vendor and CalOptima. Options include State Membership BIC file or data file provided by CalOptima.
        - CalOptima will provide Vendor with a list of fields for each form type that is required. If the record is blanked or spaced, the record is rejected.

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g. Vendor to obtain approval from CalOptima for any changes to logic impacting production file no less than 24 hours prior to the change being implemented.

h. Vendor will coordinate a testing process of all upgrades to production logic prior to migration into production.

i. Vendor shall provide CalOptima a management report or file to report rejected record activity per provider and a total record count for each daily file for reconciliation purposes.

j. Vendor will be able to receive CalOptima claims from other Clearing House vendors, convert them to CalOptima standards, and include records into CalOptima's daily files.

k. Vendor shall be able to support aggressive outreach and support activities directly with Providers to improve EDI submissions rates.

l. Vendor shall contact providers and encourage them to send data electronically.

m. Vendor shall provide telephone support to CalOptima and its providers between the hours of 6:00 am (PST) and 6:00 pm (PST) at a minimum.

n. Vendor shall provide custom support visits to CalOptima's office, as necessary.

o. Vendor to provide a secure and reliable technical infrastructure to support Services. Changes to current infrastructure shall be communicated to CalOptima. Current infrastructure includes the following:

- The "host" where the servers are located has two layers of battery backup to go through before diesel-powered generators are engaged for power. All disk storage is backed up onto tape every night. All disk storage is stored redundantly for quick recovery in case of disk failure. Vendor to have emergency phone numbers and e-mail addresses for CalOptima use in case of system emergencies. Vendor's network and servers are simple, secure and stable. Update is better than 99.9%.
- The "host" network of servers is reduntantly connected to all three major Internet backbones (MCI, Sprint and UUNet). Each backbone connection is via direct T3 links, providing Vendor with over 130 Megabits per second of transfer available straight to the backbone.
- The servers are hosted in a world-class climate-controlled machine room with rigid temperature and humidity control. All power is filtered and emergency power is always available via battery backup systems and backup generators capable of providing continuous power indefinitely.

p. Vendor's web site is to be HIPAA compliant and compliant with any and all new government regulations.

- CalOptima allows Vendor to use the "CalOptima" name in their listing of current customers. Vendor to obtain prior approval from CalOptima for all other advertising.

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EXHIBIT B

FEE SCHEDULE

1. Vendor shall be paid $0.25 cents for all claims transmitted to CalOptima (HCFA-1500, UB92, 25-1).
2. Vendor shall manually review all claims denied for eligibility reason if desired by submitting entity. The standard per claim fee ($0.25 cents) to be charged to CalOptima if and only if the member is determined as eligible and the record is therefore transmitted to CalOptima.
3. Vendor agrees to transmit claims electronically to CalOptima within 24 hours except when claims are received by Vendor after 5:00 p.m. on a Federal Holiday or a weekend, in which case, Vendor will transmit to CalOptima on the following business day. (HCFA-1500, UB92)
4. Vendor agrees to transmit claims LTC facility claims (typically 25-1 inbound file format) to CalOptima in line with a mutually agreeable timeframe.
5. Vendor shall be paid $0.25 cents for all attachments (without regard to the number of pages). CalOptima shall only pay for attachments if they are viewed by CalOptima.

EXHIBIT C

BUSINESS ASSOCIATE PROTECTED HEALTH INFORMATION DISCLOSURE AGREEMENT

This Business Associate Protected Health Information Disclosure Agreement ("Agreement') is entered into as of July 1, 2004, by and between CalOptima ("Plan") and Office Ally, L.L.C. ("Business Associate").

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations");

WHEREAS, the Privacy Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 Individual means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.3 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan.

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1.4 Required By Law means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.5 "Services" has the same meaning as in the Services Agreement(s).

1.6 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.7 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services , and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.2 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

2.3 Reporting Non-Permitted Use or Disclosure. Business Associate shall report to Plan each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors but is not specifically permitted by this Agreement. The initial report shall be made by telephone call to Laura Blank, telephone number (714) 246-8499 (Plan's Privacy Officer) within five (5) business days from the time the Business Associate becomes aware of the non-permitted Use or Disclosure, followed by a full written report to the Privacy Officer no

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later than twenty (20) business days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure. If Business Associate is unable to provide a full written report within the stated time frames, Business Associate may request an extension of up to ten (10) additional business days. Such requests shall be in written form (facsimile is acceptable), and submitted to Plan's Privacy Officer within the original twenty (20) business day deadline, and must contain an explanation for the basis of the requested extension. Plan retains the right to approve or deny such requested extensions; however Plan shall not unreasonably deny such requests.

2.4 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5. Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining Plan's compliance with the Privacy Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary and provide Plan with copies of any documents produced in response to such request.

2.6 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.7 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.8 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.8 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;
(c) a brief description of the Protected Health Information disclosed; and

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(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure (but beginning no earlier than April 14, 2003). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

(c) pursuant to a written authorization given by or behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.8 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect, including any such Services Agreement(s) entered into by the parties after the effective date of this Agreement. Business Associate's obligations under Sections 2.1 (as modified by Section 4.2), 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 4.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan;

(b) Immediately terminate this Agreement and the Services Agreement(s) if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of the federal Department of Health and Human Services.

3.3 Disposition of Protected Health Information Upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan. This provision shall apply to Protected Health Information

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that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. If return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy Regulations.

EXECUTION

Subject to the execution of the State Contract by CalOptima and the State, this Agreement shall become effective as of July 1, 2004 ("Effective Date").

In witness thereof, the parties have executed this Contract:

Business Associate

Brian P. O'Neill
Print Name

Signature

President/CEO
Title

6/30/04
Date

CalOptima

AMY PARK
Print Name

Signature

CFO
Title

7/6/04
Date

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ORIGINAL

AMENDMENT NO. 1 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 1 TO THIS AGREEMENT is entered into as of the 1st day of July, 2005, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004; and

B. CalOptima and VENDOR agree to exercise the option in paragraph 5 of the Agreement to extend the Initial Term by one year, using the first of three Renewal Terms. The new termination date shall be changed to June 30, 2006;

C. CalOptima and VENDOR agree that there are two remaining Renewal Terms in the Agreement. The second Renewal Term, if exercised, shall be from July 1, 2006 through June 30, 2007. The third and final Renewal Term, if exercised, shall be from July 1, 2007 through June 30, 2008; and

D. CalOptima and VENDOR agree to incorporate language required by the Center for Medicare and Medicaid Services (CMS) for CalOptima's new Medicare Advantage Program under a new Section 14 as follows:

14. MEDICARE ADVANTAGE PROGRAM.

(a) In addition to compliance with the provisions of Section 15(a) below, VENDOR expressly warrants that VENDOR and VENDOR'S subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions, including but not limited to all Medicare laws applicable to marketing. VENDOR further agrees and

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acknowledges that this provision will be included in any and all agreements with VENDOR'S subcontractors.

(b) For any medical records or other health and enrollment information VENDOR maintains with respect to Medicare enrollees, VENDOR shall establish procedures to:

i. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. VENDOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify (a) the purpose or purposes the information will be used within VENDOR'S organization; and (b) to whom and for what purpose VENDOR will disclose the information.

ii. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

iii. Maintain the records and information in an accurate and timely manner.

iv. Ensure timely access by enrollees to the records and information that pertain to them.

(c) VENDOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR section 422.257. Notwithstanding the preceding sentence, the parties hereto expressly agree and acknowledge that the provisions of 42 CFR 422.516 and 42 CFR 422.257 are not applicable to this Agreement.

(d) In addition to the termination provisions of Section 5 of this Agreement, VENDOR agrees and acknowledges that CalOptima may terminate the Agreement if CMS or CalOptima determines that VENDOR has not satisfactorily performed its obligations under the Agreement. Under such circumstances, CalOptima may pay VENDOR its allowable costs

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incurred to the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima for matters pertaining to this Agreement.

(e) While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its Agreement with CMS, VENDOR shall comply with all such requirements at the direction of CalOptima.

(f) CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with VENDOR and VENDOR'S performance of this Agreement.

(g) Notwithstanding the delegation by CalOptima to VENDOR the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

Notwithstanding the written delegation by CalOptima to VENDOR of any other activities under this Agreement, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its Agreement with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with VENDOR. With all such delegated activities, CalOptima shall monitor VENDOR'S performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements."

E. Renumber Section 14, GENERAL, as a new Section 15.

F. SIGNATURES -- This Amendment No. 1 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 1 to the Agreement to be executed on the date first above written.

~~Office Ally, L.L.C.~~	CalOptima
By: _____	By: _____ 8/25/05
Brian P. O'Neill	~~Amy Park~~ Dr. Greg Buchert
President/Chief Executive Officer	Operating Chief ~~Financial~~ Officer

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ORIGINAL

AMENDMENT NO. 2 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 2 TO THIS AGREEMENT is entered into as of the 1st day of July, 2006, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004;

B. CalOptima and VENDOR exercised the first of three one year Renewal Terms on July 1, 2005;

C. CalOptima and VENDOR agree to exercise the second Renewal Term for July 1, 2006 through June 30, 2007. The new termination date shall be changed to June 30, 2007;

D. CalOptima and VENDOR agree that there is one remaining Renewal Term in the Agreement. The third Renewal Term, if exercised, shall be from July 1, 2007 through June 30, 2008;

E. SIGNATURES -- This Amendment No. 2 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 2 to the Agreement to be executed on the date first above written.

Office Ally, L.L.C.	CalOptima
By: _____	By: _____
Brian P. O'Neill	Keith Quinlivan
President/Chief Executive Officer	Chief Financial Officer

/

/

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AMENDMENT NO. 3 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 3 TO THIS AGREEMENT is entered into as of the 26th day of June, 2007, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004;

B. CalOptima and VENDOR agree to exercise the third and final Renewal Term and extend such Term to June 30, 2008;

C. SIGNATURES -- This Amendment No. 3 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 3 to the Agreement to be executed on the date first above written.

Office Ally, L.L.C.	CalOptima
By: _____	By: _____ for
Brian P. O'Neill	Keith Quinlivan 7/25/07
President/Chief Executive Officer	Chief Financial Officer

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AMENDMENT NO. 4 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 4 TO THIS AGREEMENT is entered into as of the 26th day of June, 2008, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to maintain the current fee schedule and to use Contract No. MC 03299 as a Purchase Order number to bill for the clearinghouse services performed effective July 1, 2008; and

C. CalOptima and VENDOR agree to extend the terms of the Agreement under Contract No. MC 03299 to the 30th day of June, 2009.

SIGNATURES -- This Amendment No. 4 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 4 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Chief Financial Officer

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AMENDMENT NO. 5 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 5 TO THIS AGREEMENT is entered into as of the 6th day of November, 2008, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to modify the Scope of Work to contract MC 03299 to include electronic delivery of the PM160 document. The PM160 document is defined as the document that captures the pediatric preventative service that is shared with the state in the Child Health and Disability Prevention (CHDP) program. CalOptima agrees to pay VENDOR $0.25 per PM160 delivered electronically to CalOptima. All other terms and conditions remain otherwise unchanged.

SIGNATURES -- This Amendment No. 5 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 5 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Rita Vitagliano

Director of Finance and Procurement

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AMENDMENT NO. 6 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 6 TO THIS AGREEMENT is entered into as of the 16th day of February, 2009, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2010.

SIGNATURES -- This Amendment No. 6 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 6 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: Richard Chambers

Richard Chambers

Chief Executive Officer

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AMENDMENT NO. 7 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 7 TO THIS AGREEMENT is entered into as of the 2nd day of June, 2010, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to modify the payment terms of Amendment 5 Section B to reduce the price of the PM 160 R11 from $.25 to $.15. All other prices shall remain the same; and

C. VENDOR agrees to provide an SAS 70 Type II equivalent report ensuring internal controls are in place protecting PHI connected with electronic transmission of claims data; and

D. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2011.

SIGNATURES -- This Amendment No. 7 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 7 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: Richard Chambers

Richard Chambers

Chief Executive Officer

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AMENDMENT NO. 8 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 8 TO THIS AGREEMENT is entered into as of the 18th day of June, 2011, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2012.

SIGNATURES -- This Amendment No. 8 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 8 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian O'Neill

President / CEO

CalOptima

By: _____

Richard Chambers

Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Chief Financial Officer

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RE: attachments

Perikly, Jaime

Sent: Friday, June 17, 2011 3:59 PM

To: Aleshire, Ryan

One year.

From: Aleshire, Ryan
Sent: Friday, June 17, 2011 3:59 PM
To: Perikly, Jaime
Subject: RE: attachments

Yes, that would be fine. How long should the contract be extended?

Regards,

Ryan Aleshire
Sr. Buyer
CalOptima
Phone: (714) 246 8714
eFax: (714) 571 2499

From: Perikly, Jaime
Sent: Friday, June 17, 2011 3:58 PM
To: Aleshire, Ryan
Subject: RE: attachments

Ryan,

Can we just draft an extension amendment like the most recent one that expires at the end of the month for now? We will need to redo the scope, but there is much more missing that needs to be added. In the interest of time, I think it is best to keep it as is since they are not having any major issues at the moment.

Your thoughts?

From: Aleshire, Ryan
Sent: Friday, June 17, 2011 3:52 PM
To: Perikly, Jaime
Subject: RE: attachments

See attached.

Regards,

Ryan Aleshire
Sr. Buyer
CalOptima
Phone: (714) 246 8714
eFax: (714) 571 2499

From: Perikly, Jaime
Sent: Friday, June 17, 2011 3:45 PM
To: Aleshire, Ryan
Subject: FW: attachments

Do you have the full copy of the contract in its entirety? I want to be sure that we have some specific language in there about the pricing and service expectations before I finish up this amendment.

Thanks!

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 17, 2011 3:39 PM
To: Perikly, Jaime
Cc: Brannon, Sabrina; Aleshire, Ryan
Subject: RE: attachments

Jamie,

Since this is a scanned pdf it doesn't look like I can copy and paste anything from it.

Laurie

From: Perikly, Jaime [mailto:jperikly@caloptima.org]
Sent: Friday, June 17, 2011 3:26 PM
To: 'Laurie Kirkland'
Cc: Brannon, Sabrina; Aleshire, Ryan
Subject: RE: attachments

Laurie,

Thanks for checking. I am handling the new amendment for this year. Can you copy and paste from last year and forward to me ASAP?

Jaime Perikly, PMP
Director, eBusiness and Project Management Office
CalOptima
Telephone: (714) 246-8813
Fax: (714) 571-2472
E-mail: jperikly@caloptima.org

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 17, 2011 3:23 PM
To: Perikly, Jaime
Subject: RE: attachments

Hi Jamie,

I was looking for our original contract and it must have been misplaced during our move- but it should have had attachments included on it. I left a message with Marcia because I wanted to see if she remembers implementing with us – someone over there did before 2008. Anyway we charge $0.20 for all attachments that go with one claim. We must not have ever charged you for them either. Sabrina has asked me to create the yearly contract with you, do you want me to copy and paste from last year or will you supply that to me?

Laurie

From: Perikly, Jaime [mailto:jperikly@caloptima.org]
Sent: Monday, June 13, 2011 2:32 PM
To: 'Laurie Kirkland'
Subject: FW: attachments

Laurie,

Can you please provide for me the costs for the attachments? There is nothing in the existing agreement that spells out what the costs were. Also, I do not think we ever requested or approved the allowance of the attachments and worked out the process. Can you please advise?

Can you give me more details on the PM160 demo account that created?

Thanks!

Jaime Perikly, PMP
Director, eBusiness and Project Management Office
CalOptima
Telephone: (714) 246-8813
Fax: (714) 571-2472
E-mail: jperikly@caloptima.org

From: Kodama, Janine

Sent: Friday, June 10, 2011 8:58 AM
To: Perikly, Jaime
Subject: FW: attachments

Hi Jaime, can you assist Laurie below. Not sure what she's referring regarding PM160 demo. There was a 2nd phase we were waiting for to enhance the PM160 process but never received additional information. If you have additional questions, please let me know. Thanks.

Thanks,

Janine Kodama
Coding Quality Manager, Coding Initiatives
CalOptima
Email: jkodama@caloptima.org
Phone: (714) 246-8440
Fax: (714) 481-6506

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 10, 2011 8:30 AM
To: Kodama, Janine
Subject: attachments

Hi Janine,

I was wondering if you have decided what to do about the attachments we are still posting to you but you are not picking up. I spoke to one of your providers that mentioned she is sending claims electronically to you through us but then she is going to CMS Mgmt online and uploading her reports and she typically is hearing that the 2 are not syncing up.
Should we be shutting off the attachment option for you? We can also deliver them via SFTP if you prefer.

On another subject – any idea where the PM 160 stands? We gave you access to a demo account with all the new updates in early May but never heard back.

Laurie Kirkland
Office Ally
Director of Business Development
866-575-4120 ext 215

(20110610) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

_____ Information from ESET NOD32 Antivirus, version of virus signature database 6196 (20110610) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

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_____ Information from ESET NOD32 Antivirus, version of virus signature database 6204 (20110613) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

_____ Information from ESET NOD32 Antivirus, version of virus signature database 6218 (20110617) _____

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http://www.eset.com

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AMENDMENT NO. 9 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 9 TO THIS AGREEMENT is entered into as of the 26th day of June, 2012, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima entered into Amendments 1 though 8 between July 1, 2005 and June 18, 2011.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2013.

SIGNATURES -- This Amendment No. 9 to the Contract shall be made effective upon execution by both parties. IN **WITNESS WHEREOF, the parties** hereto have caused this Amendment No. 9 to the Contract to be executed on the **date first above written.**

Office Ally, LLC

By: _____

Brian O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Interim Chief Executive Officer

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AMENDMENT NO. 10 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 10 TO THIS AGREEMENT is entered into as of the 11th day of June, 2013, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the terms of the Agreement to December 31, 2016.

SIGNATURES -- This Amendment No. 10 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 10 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Patti McFarland

Chief Financial Officer

By: _____

Michael Schrader

Chief Executive Officer

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CalOptima
A Public Agency
Better. Together.

Orange, CA 92868
(714) 246-8400

Purchase Order No	17-10226
PO Date	8/25/2016
Delivery Date	8/24/2017
Buyer	Kim Marquez
FOB	BEST METHOD
Shipping Point	Orange
Payment Terms	Net 30 Days
Shipping Method	Best Method
Page	1

Vendor: Office Ally, LLC
8415 Datapoint Drive
Suite 900
San Antonio TX 78229

Phone: (866) 575-4120 Ext. 00(
Fax: (000) 000-0000 Ext. 00(

Ship To: CalOptima - MediCal
Mike Herman/PO 17-10226
505 City Parkway West
Orange CA 92868

^ Changed Since The Previous Revision

Number	Qty	Item U/M	Stock Number	Description	Unit Price	Extended Price
1	1	Each	SER-061-512	Clearinghouse Set Up Fee For implementation of hosting of 270/271 and 276/277 Transactions. Timeframe 1-2 weeks. Per Contract MC 03299, Amendment #11. One time fee.	$4,500.00	$4,500.00
2	12	Each	SER-060-262	EDI Clearinghouse Services Monthly fee of $1,200 per month for hosting 270/271 and 276/277 transactions. Effective 8/25/2016 for first 12 months. Per Contract MC 03299 Amendment No. 11.	$1,200.00	$14,400.00

Req #: 19105/amillspaugh

Verbal additions, deletions, or modifications of any kind to this purchase order shall be considered unauthorized and invalid. Do not accept verbal modifications from any employee, agent, or implied or apparent agent of CalOptima. Valid modifications to this purchase order shall be in the form of a written notice signed by an authorized member of the CalOptima Procurement staff.

Invoices received in excess of the total amount of this purchase order shall be considered unauthorized and, as such, may not be paid. Terms and conditions appearing on the reverse side are hereby incorporated.

PO NUMBER MUST APPEAR ON PACKING SLIP.
TO ASSIST WITH RECEIPT OF GOODS AND ENSURE PAYMENT OF VENDOR INVOICE(S), ALL ITEMS BEING DELIVERED DIRECTLY TO CALOPTIMA FROM THE MANUFACTURER MUST INDICATE CALOPTIMA'S PURCHASE ORDER NUMBER ON THE PACKING SLIP.

Subtotal	$18,900.00
Trade Discount	$0.00
Freight	$0.00
Miscellaneous	$0.00
8.00% Sales Tax	$0.00
Order Total	$18,900.00

See Contract for Signature
Authorized Signature Date

AMENDMENT NO. 11 TO CONTRACT MC 03299
DATA CLEARINGHOUSE AGREEMENT

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
dba ORANGE PREVENTION AND TREATMENT ITEGRATED MEDICAL ASSISTANCE, dba
(CalOptima)

AND

OFFICE ALLY, INC
(VENDOR)

AMENDMENT NO. 11 TO THIS CONTRACT is entered into as of this 25th day of August, 2016, with respect to the following facts:

A. CalOptima and Office Ally (hereinafter collectively referred to as "the Parties") entered into Contract MC 03299 on July 1, 2004, under which agreed to provide Data Clearinghouse Services (hereinafter, "Contract").

B. Pursuant to Section 14 (o), the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by modifying Exhibit A to include additional services, and Exhibit B to include additional fees.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. CalOptima and Office Ally agree to modify Exhibit A - Scope of Services to include a new hosted service for 270/271 and 276/277 transactions. This is to include the initial set up and ongoing monthly service. Office Ally will host this data by way of a set of eligibility and claims "flat files" from CalOptima and respond to provider system real-time inquires and responses with HIPAA ANSI x12 EDI transactions 270/271 Eligibility and 276/277 Claims.

3. CalOptima and Office Ally agree to modify Exhibit B - Fee Schedule to include an initial Setup fee of $4,500.00 for the 270/271 and 276/277 hosting service. CalOptima and Office Ally also agree to a monthly fee of $1,200.00 for, unlimited, hosting and responding to inquiries via these 270/271 and 276/277 transactions.

4. No Other Changes. This Amendment No. 11 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 11 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 11 on the day and year last shown below.

"CALOPTIMA"

Date: 8-31-16

By: Ken Wong
Its: Director of Budget and Procurement

Date: 8/29/2016

"VENDOR"

By: BRIAN P O'NEILL
Its: PRESIDENT/CFO
[Chairman, President or Vice President]

By: Gloria Chung
Its: COO
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

AMENDMENT NO. 12 TO
CONTRACT MC 03299
Data Clearinghouse Agreement

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
dba
(CalOptima)

AND

OFFICE ALLY, INC.
(VENDOR)

AMENDMENT NO. 12 TO THIS CONTRACT is entered into as of this 22ND day of September, 2016, with respect to the following facts:

A. CalOptima and Vendor (hereinafter collectively referred to as "the Parties") entered into Contract MC 03299 on July 1, 2004, under which agreed to edit and validate claims for submission to CalOptima (hereinafter, "Contract").

B. Pursuant to Section 14 (o) of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by extending the contract term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The Term of the Contract and all Amendments to the Contract are hereby extended through December 31, 2020.

3. **No Other Changes.** This Amendment No. 12 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 12 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 12 on the day and year last shown below.

"CALOPTIMA"

Date: 10-7-16

By: Michael Schrader
Its: Chief Executive Officer

By: ~~Chief Admin~~ Ladan Khamseh
Its: ~~CFO~~ CFO

Date: 10/4/2016

"VENDOR"

By: BRIAN P O'NEIL
Its: President/CFO
[Chairman, President or Vice President]

By: Gloria C. Chung
Its: C.C.O.
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024

Contact

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

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024:

1. Submission of a proposal to the California Department of Health Care Services to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024;
2. Pursuit of funding partnerships with eligible participating entities; and
3. The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek intergovernmental transfer funds.

Background

The Voluntary Rate Range Intergovernmental Transfer Program (VRRP) allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars through intergovernmental transfers from eligible Orange County governmental entities. The eligible governmental entities are public entities, including counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state.

For each Intergovernmental Transfer (IGT) transaction, DHCS identifies the estimated CalOptima member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. Participating governmental entities transfer public funds to DHCS, which is then used by DHCS to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in thirteen transaction cycles of the VRRP.

CalOptima Health retains a 2% administrative fee of net proceeds to offset expenses for the administration of the VRRP.

There were seven program participants in the CY 2023 IGT 13 round:

- UCI Health;
- County of Orange;
- City of Orange;
- First 5 Orange County (formerly known as the Children and Families Commission);
- City of Newport Beach;
- City of Huntington Beach; and
- City of Fountain Valley.

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Discussion

On January 14, 2025, CalOptima Health received notification from DHCS regarding the IGT 14 opportunity with up to $175.1 million in total funding availability for Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than March 28, 2025.

On February 4, 2025, CalOptima Health hosted an informational webinar and shared information about VRRP to potential participating eligible governmental entities to inform them of the CY 2024 VRRP (IGT 14) timeline, funding availability, submission process, and eligibility requirements that must be met in order to be considered for funding.

Eligible governmental entities must meet the following requirements:

- Only governmental entities that incur uncompensated costs for covered Medi-Cal services may be eligible for funding;
- Funding entities may not use recycled Medicaid funds or federal funds that are not eligible to fund the state share of the IGT;
- Funding entities must be:
    - Contracted CalOptima Health providers with uncompensated Medi-Cal expenditures, or costs which exceed payment from the plan for services rendered to Medi-Cal members.
    - Interested in providing local funds to act as a local IGT match.
- Funding entities must:
    - Certify that the funds provided are eligible for federal matching dollars.
    - Document uncompensated services (costs above reimbursement) provided to CalOptima Health members for dates of service between July 1, 2022, through June 30, 2023.

CalOptima Health staff is seeking Board of Directors' approval to authorize staff to submit the proposal letter to DHCS for participation in IGT 14 and to authorize the Chief Executive Officer to enter into agreements with each of the confirmed participating funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. CalOptima Health staff will review the estimated contribution amounts and uncompensated Medi-Cal expenditures from participating funding entities to determine the IGT 14 allocation. Staff will return to the Board of Directors with the final list of participating funding partners and allocations for ratification at the April 3, 2025, meeting of the Board.

Consistent with the most recent IGT transaction, CalOptima Health will retain an administrative fee of 2% of net proceeds, with the remaining net proceeds distributed to the funding entities in compliance with VRRP requirements.

Fiscal Impact

Staff anticipate the recommended actions to be net budget neutral to CalOptima Health. IGT 14 is expected to generate approximately $2.6 million for CalOptima Health to offset expenses for the administration of the VRRP.

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Rationale for Recommendation

Submission of the proposal and authorization of funding agreements will allow CalOptima Health to maximize Orange County's available Medi-Cal funding for Calendar Year 2024. It will also increase dollars to participating entities in Orange County to support Medi-Cal services provided to CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CY 2024 Department of Health Care Services VRRP Notification
2. CY 2024 Attachment B Form for Governmental Funding Entities
3. Previous Board Action dated August 1, 2024, "Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)"

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

January 14, 2025

Nancy Huang
CFO
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year 2024 (January 1, 2024 – December 31, 2024) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Nancy Huang:

The Calendar Year 2024 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2024, through December 31, 2024.

DHCS shall not direct the MCP's expenditure of payments received under the Calendar Year 2024 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Calendar Year 2024 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2024:

MCPs should refer to the estimated Calendar Year 2024 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Calendar Year 2024 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated Contribution (Non-Federal Share) amounts are based on final amended capitation rates (as of January 2025) and estimated member months, and the actual amounts may change based on finalized rates and updated enrollment estimates.

If an MCP elects to participate in the Calendar Year 2024 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Calendar Year 2024 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on **MCP letterhead**.
    2. The MCP's primary contact information (name, title, e-mail address, mailing address, and phone number).
    3. Rating region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Calendar

Year 2024. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.

4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Calendar Year 2024 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on **the participating governmental funding entity's letterhead**. A separate letter of interest must be provided for each rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2024 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by **Friday, March 28, 2025**.

    - Please note: For MCPs that entered new rating regions in Calendar Year 2024, DHCS is granting a one-time exemption for Attachment B reporting from governmental funding entities in these rating regions. DHCS has indicated exempt rating regions for each MCP on the Attachment C documents using **purple highlight and a footnote**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, March *28, 2025***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Calendar Year 2024 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges unless the applicable rating region is subject to a one-time exemption. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Calendar Year 2024 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement

documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

January 14, 2025

Michael Jordan Staff Services Manager II
Capitated Rates Development Division

Attachments

cc: Michael Hunn
CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Vivian Beeck
Staff Services Manager I
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Scott Gale
Associate Governmental Program Analyst
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)

Contact

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

Recommended Actions

Ratify the following list of qualifying funding partners and allocations for participation in the Calendar Year 2023 Voluntary Rate Range Intergovernmental Transfer Program:

1. City of Fountain Valley Fire Department;
2. City of Huntington Beach Fire Department;
3. City of Orange Fire Department;
4. City of Newport Beach Fire Department;
5. Children and Families Commission of Orange County (First 5 of Orange County);
6. County of Orange Health Care Agency; and
7. University of California, Irvine.

Background

The Voluntary Rate Range Intergovernmental Transfer (IGT) program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, eligible entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions. CalOptima Health currently retains a 2% administrative fee of net proceeds for administration of the Voluntary Rate Range IGT program.

On May 29, 2024, DHCS notified CalOptima Health regarding the Calendar Year (CY) 2023 Voluntary Rate Range IGT program opportunity with up to $52.5 million in contribution for Orange County. CalOptima Health's submission of the required materials was due to DHCS by July 10, 2024. At the June 6, 2024, Board of Directors meeting, staff received approval to pursue funding partnerships with eligible entities, submit the proposal to DHCS, execute agreements with the funding entities, and bring back the final list of funding partners and allocation at the August 1, 2024, Board of Directors meeting.

Discussion

CalOptima Health contacted the six CY 2022 Voluntary Rate Range program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT

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program timeline and funding availability. CalOptima Health also reached out to the City of Fountain Valley as they had recently inquired and expressed interest in participating.

CalOptima Health submitted the proposal to DHCS, along with the proposed funding entities' supporting documents, on July 8, 2024. The entities and their approximate contribution amounts are:

Funding Entity	**Calendar Year 2023 Total Transfer Amount**	**Calendar Year 2023 Total Participation Percentage (%)**
Children & Families Commission of Orange County (First 5 of Orange County)	$804,153	1.53%
City of Fountain Valley Fire Department	$779,540	1.48%
City of Huntington Beach Fire Department	$2,292,744	4.36%
City of Newport Beach Fire Department	$367,822	0.70%
City of Orange Fire Department	$579,294	1.10%
County of Orange Health Care Agency	$3,547,480	6.75%
University of California, Irvine	$44,180,379	84.07%
Total Funding Entities Participation	$52,551,412	100%
Unfunded	$0	0%
Total Available Non-federal Share IGT	$52,551,412	-

Due to the timing of the submission, CalOptima Health staff request the Board of Directors ratify the list of funding partners and the funding allocations above that were submitted for the CY 2023 Voluntary Rate Range IGT to DHCS on July 8, 2024.

Fiscal Impact
The recommended action is net budget neutral and has no additional fiscal impact.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements allows Orange County eligible funding partners to participate in the CY 2023 Voluntary Rate Range IGT program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated June 6, 2024, Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023.
3. CalOptima Health Calendar Year 2023 Voluntary Rate Range Program Letter of Interest and Proposal to DHCS.
4. CY 2023 DHCS Attachment C CalOptima Health Estimated Funding Allocation.

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708
City of Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange Fire Department	300 E. Chapman Avenue	Orange	CA	92866
County of Orange Health Care Agency	405 W. 5th Street, Suite 756	Santa Ana	CA	92701
First 5 Orange County Children & Families Commission	1505 E. 17th Street, Suite 230	Santa Ana	CA	92705
University of California, Irvine Medical Center	101 City Drive, Bldg 53, Suite 100	Orange	CA	92868

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023

Contact

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

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2023 (IGT 13):

1. Submission of a proposal to the California Department of Health Care Services to participate in IGT 13;
2. Pursuit of funding partnerships with eligible participating entities; and
3. The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek IGT 13 funds.

Background

The Voluntary Rate Range IGT program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions.

CalOptima Health retains a 2% administrative fee of net proceeds to offset expenses for the administration of the Voluntary Rate Range IGT program.

Discussion

On May 29, 2024, CalOptima Health received notification from DHCS regarding the IGT 13 opportunity with up to $160.5 million in total funding availability for Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than June 28, 2024.

CalOptima Health will contact the six CY 2022 program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT program timeline and funding availability. CalOptima Health will also reach out to additional potentially eligible funding partners to inform them of the program timeline and requirements.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 13 and to authorize the Chief Executive Officer to enter into agreements with each of the identified

funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. Staff will submit to the Board the final list of funding partners and allocations for ratification at the August 1, 2024, meeting of the Board.

Fiscal Impact

Staff anticipates IGT 13 will be net budget neutral to CalOptima Health. CalOptima Health will retain a 2% administrative fee of net proceeds or approximately $1.95 million to offset expenses for the administration of the program. The remaining net proceeds will be distributed to the participating IGT funding entities.

Rationale for Recommendation

Submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2023. It will increase dollars to funding entities in Orange County to support Medi-Cal services to CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter
2. CY 2023 DHCS Attachment B Voluntary Rate Range Program – DHCS Template
3. CY 2023 DHCS Attachment C – CalOptima Health Estimated Funding Allocation
4. CY 2023 Voluntary Rate Range Letter of Intent Template
5. Prior Year – CY 2022 Voluntary Rate Range Program Participating Entities

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Michelle Baass | Director

May 13, 2024

Peter Bastone
Chief Strategy Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year (CY) 2023 (January 1, 2023 – December 31, 2023) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Peter Bastone:

The Calendar Year 2023 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2023, through December 31, 2023.

DHCS shall not direct the MCP's expenditure of payments received under the CY 2023 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

California Department of Health Care Services
Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413
Sacramento, CA, 95899-7413
MS 4413 | Phone (916) 345-7070 | Fax (916) 650-6860
https://www.dhcs.ca.gov/

DHCS shall continue to administer all aspects of the IGT related to the CY 2023 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2023:

MCPs should refer to the estimated CY 2023 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the CY 2023 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated contribution (Non-Federal Share) amounts are based on CY 2023 capitation rates delivered to plans in May 2024, and actual member months (as of March 2024). Actual amounts may change based on finalized rates and updated enrollment information.

If an MCP elects to participate in the CY 2023 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the CY 2023 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on **MCP letterhead**.
    2. The MCP's primary contact(s) information (name(s), title(s), e-mail address(s), mailing address(s), and phone number(s)).

3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for CY2023. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the CY 2023 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A (included below) must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2023 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by **Friday, June 28, 2024**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *June 28, 2024***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, Michael.Ha@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the CY 2023 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the CY 2023 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

Michael Jordan
Staff Services Manager II
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachments

cc: Vivian Beeck
Staff Services Manager I
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Michael Ha
Health Program Specialist
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P.O. Box 997413, MS 4413
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Scott Gale
Associate Governmental Program Analyst
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: _____

Signature & Date: _____

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Voluntary Rate Range Program
Attachment C
January 1, 2023 - December 31, 2023

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 23 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,472,048	99.09	$ 106.27	$ 7.18	$ -	$ 7.18	$ 24,929,305	$ 10,525,551	42.22%
506	CalOptima	Orange	Child	UIS	148,873	32.09	$ 34.73	$ 2.64	$ -	$ 2.64	$ 393,025	$ 177,141	45.07%
506	CalOptima	Orange	Adult	SIS	1,423,569	212.50	$ 225.70	$ 13.20	$ -	$ 13.20	$ 18,791,110	$ 8,573,220	45.62%
506	CalOptima	Orange	Adult	UIS	267,683	178.51	$ 189.06	$ 10.55	$ -	$ 10.55	$ 2,824,056	$ 1,254,778	44.43%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,773,376	304.58	$ 322.43	$ 17.85	$ 4.46	$ 13.39	$ 50,525,505	$ 5,052,550	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	419,435	292.09	$ 308.77	$ 16.68	$ 4.17	$ 12.51	$ 5,247,132	$ 575,180	10.96%
506	CalOptima	Orange	SPD	SIS	442,469	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 20,397,821	$ 9,515,885	46.65%
506	CalOptima	Orange	SPD	UIS	86,182	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 3,595,513	$ 1,661,790	46.22%
506	CalOptima	Orange	SPD/Full-Dual	SIS	1,299,679	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 20,807,861	$ 9,720,739	46.72%
506	CalOptima	Orange	SPD/Full-Dual	UIS	6,355	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 44,104	$ 20,604	46.72%
506	CalOptima	Orange	LTC	SIS	2,597	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 119,722	$ 55,930	46.72%
506	CalOptima	Orange	LTC	UIS	1,559	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 65,041	$ 30,381	46.71%
506	CalOptima	Orange	LTC/Full-Dual	SIS	31,893	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 510,607	$ 238,539	46.72%
506	CalOptima	Orange	LTC/Full-Dual	UIS	124	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 861	$ 402	46.69%
506	CalOptima	Orange	Whole Child Model	SIS	133,436	1,761.91	$ 1,852.98	$ 91.07	$ -	$ 91.07	$ 12,152,017	$ 5,094,006	41.92%
506	CalOptima	Orange	Whole Child Model	UIS	4,171	552.77	$ 583.55	$ 30.78	$ -	$ 30.78	$ 128,383	$ 54,716	42.62%
506	**CalOptima**	**Orange**	**All COAs**		**11,513,449**	**287.15**	**$ 302.71**	**$ 15.56**	**$ 8.63**	**$ 13.94**	**$ 160,532,063**	**$ 52,551,412**	**32.74%**

Footnotes:
1 The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 23 MM effective as of March 2024.

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SHOULD BE DONE ON YOUR LETTER HEAD

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, title, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment to the June 6, 2024 Board of Directors Meeting – Agenda Item 15

Attachment 5 – Prior Year CY 2022 Voluntary Rate Range Program Participating Entities

Legal Name	Address	City	State	Zip code
City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Children and Families Commission of Orange County (First 5 Orange County)	1505 E 17th Street, Suite 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Regents of the University of California, Irvine Medical Center (UCI Health)	333 City Blvd. West, Suite 200	Orange	CA	92868

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
714-246-8400
TTY: 711
caloptima.org

July 3, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter is to confirm CalOptima Health's interest in initiating IGT for Calendar Year 2023 (January 1, 2023 through December 31, 2023) to enhance services for CalOptima Health's Medi-Cal members.

CalOptima Health is applying for the maximum amounts with one new funding entity (City of Fountain Valley) in addition to the previous participants. For Orange County's proposed IGT transaction for Calendar Year 2023, these funding entities have confirmed their participation as follows:

Funding Entity	Calendar Year 2023 Total Transfer Amount	Calendar Year 2023 Total Participation Percentage (%)
Children & Families Commission of Orange County (First 5 of Orange County)	$804,153	1.53%
City of Fountain Valley	$779,540	1.48%
City of Huntington Beach	$2,292,744	4.36%
City of Newport Beach	$367,822	0.70%
City of Orange	$579,294	1.10%
County of Orange Health Care Agency	$3,547,480	6.75%
UC Irvine Medical Center	$44,180,379	84.07%
Total Funding Entities Participation	$52,551,412	100.00%
Unfunded	$0	0%
Total Available Non-Federal Share IGT	$52,551,412	

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The seven funding entities are able to contribute up to $52,551,412, or 100 percent of the non-federal share IGT amount for Orange County. The unfunded portion is $0, or 0 (zero) percent of the non-federal share IGT amount. CalOptima Health intends to retain 2% of the transaction as an administrative fee.

Enclosed, please find the attachments as requested for each funding entity:

- Voluntary, non-binding letter of interest including:
  - Dollar amount to be contributed as non-federal share IGT
  - Funding entity contact information
  - Funding entity's Federal I.D. number
- Separate attachment for Calendar Year 2023 including the following data from July 1, 2021–June 30, 2022:
  - Inpatient/Outpatient charges, as applicable
  - Inpatient/Outpatient costs, as applicable
  - Payments for Inpatient/Outpatient services, as applicable
  - Unreimbursed costs for Inpatient/Outpatient services, as applicable scope of services

The point of contacts for CalOptima Health are:

Mr. Mike Wood
Manager, Regulatory Affairs & Compliance (Medi-Cal Regulatory Affairs)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: mwood@caloptima.org
Phone: 714-246-8415

Ms. Annabel Vaughn
Director, Regulatory Affairs & Compliance (Medi-Cal)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: avaughn@caloptima.org
Phone: 714-246-8676

Mr. John Tanner
Chief Compliance Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: john.tanner@caloptima.org
Phone: 657-235-6997

Ms. Nancy Huang
Chief Financial Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: nhuang@caloptima.org
Phone: 657-235-6935

Mr. Jason Kaing
Controller
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: jason.kaing@caloptima.org
Phone: 657-900-1373

Ms. Donna Laverdiere
Executive Director, Strategic Development
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: donna.laverdiere@caloptima.org
Phone: 714-986-6981

Please contact Mr. Mike Wood (primary contact) if you have any questions regarding this submission.

Sincerely,

Michael Hunn
Chief Executive Officer

Enclosures

cc:
Vivian Beeck, Staff Services Manager, California Department of Health Care Services
Michael Ha, Health Program Specialist, California Department of Health Care Services
Michael Jordan, Staff services Manager II, California Department of Health Care Services
Scott Gale, Associate Governmental Program Analyst, California Department of Health Care Services
Chad Lefteris, Chief Executive Officer, UC Irvine Health
Christopher Leo, Director Government Affairs, UC Irvine Health
Anza Vang, Deputy Chief of Public Health Services, Orange County Health Care Agency
William McQuaid, Fire Chief, City of Fountain Valley
Tim Saiki, Battalion Chief, City of Fountain Valley

Scott Haberle, Fire Chief, City of Huntington Beach
Jeffrey Lopez, Division Chief of Operations, City of Huntington Beach
Bonnie To, Principal Management Analyst, City of Huntington Beach
Bryan Johnson, EMS Manager, City of Orange
Nathalia Flores, Administrative Analyst, City of Orange
Jeff Boyles, Fire Chief, City of Newport Beach
Kristin Thompson, EMS Division Chief, City of Newport Beach
Raymund Reyes, Administrative Manager, City of Newport Beach
Kimberly Goll, Executive Director, First 5 Orange County Children & Families Commission
Yunkyung Kim, Chief Operating Officer, CalOptima Health
Nancy Huang, Chief Financial Officer, CalOptima Health

FIRST 5 ORANGE COUNTY

1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
714-834-5310 first5oc.org

LETTER OF INTEREST

June 25, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the Children and Families Commission of Orange County (DBA First 5 Orange County), a governmental entity, federal I.D. Number 95-6000928, in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of January 1, 2023, through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The Children and Families Commission of Orange County is willing to contribute approximately $804,153 for the Calendar Year 2023 (January 1, 2023 - December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kimberly Goll, President CEO
Children and Families Commission of Orange County
1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
(714) 920-2598
Kim.Goll@cfcoc.ocgov.com

You may also contact our consultant, Gelmy Ruiz, with any questions or concerns regarding our participation in the IGTs. Her contact information is (916) 329-8234 or gruiz@healthmanagement.com.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Kimberly Goll
President/CEO

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	Children and Families Commission of Orange County
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other		$ 930,973.14		$ -	$ 930,973.14
Total	$ -	$ 930,973.14	$ -	$ -	$ 930,973.14

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? **Yes**

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The Children and Families Commission of Orange County (First 5 Orange County) health care services are provided to children aged 0-5 and their caregivers and encompass pre and post-natal maternal health screenings; postpartum depression screening and referrals; lactation education and aid; parenting education; case management, care coordination, and referrals to home visits to support the at-risk, postpartum population; and the provision of development assessments and screenings to identify children with autism and neurodevelopmental disorders. First 5 Orange County does not have a contract with CalOptima for services.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: Children and Families Commission of Orange County

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County Commission

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Tobacco tax revenue collected by the State and distributed to Counties based on birthrates to develop, adopt, promote, and implement local early children development programs.

(iv) Does the transferring entity have general taxing authority? **No**

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. **Yes, 80% of revenue collected is distributed to counties.**

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Kimberly Goll, President/CEO

Signature & Date: Kimberly Goll

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FOUNTAIN VALLEY

10200 Slater Avenue
Fountain Valley, CA 92708
Phone: (714) 593-4412
Fax: 714-593-4494
fountainvalley.gov

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Fountain Valley, a governmental entity, Federal I.D. Number 95-2158356 (NPI: 1528109212), in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Fountain Valley is willing to contribute approximately $779,540 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:
William McQuaid, Fire Chief
10200 Slater Avenue
Fountain Valley, CA 92708
Email – bill.mcquaid@fountainvalley,gov
Office (714) 593-4436
Cell (714) 336-6844

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

William McQuaid 6/27/24

William McQuaid
Fire Chief

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Fountain Valley
County:	Orange County, CA
Health Plan:	CalOptima Health

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 894,656.97	$ 680,781.45	$ 115,116.04	$ 779,540.93	$ 565,665.41
Total	$ 894,656.97	$ 680,781.45	$ 115,116.04	$ 779,540.93	$ 565,665.41

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The City of Fountain Valley provides 911-response to medical calls, traffic accidents, and other emergencies requiring emergency medical care. The City's service model includes Advance Life Support (ALS) response daily via 3 fire apparatus (two engines, one ladder truck) with 1 company officer, 1 fire engineer, and 2 firefighter/paramedics each. It also includes two Basic Life Support (BLS) ambulances daily with 2 emergency medical technitions (EMTs) on each ambulance.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Fountain Valley

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.) General Fund

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

CalOptima charges and payments provided via billing report from our contracted billing provider (Wittman). Costs calcuated using Fiscal Year 21/22 actual budget, CalOptima transport statistics from Wittman, and CAD data (call volume).

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: William McQuaid Fire chief

Signature & Date: [signature] 6/27/2024

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HUNTINGTON BEACH FIRE DEPARTMENT

2000 Main Street
California 92648

Phone: (714) 536-5411
www.huntingtonbeachca.gov

Scott M. Haberle
Fire Chief

June 24, 2024

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services 1501
Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Huntington Beach, a governmental entity, federal I.D. Number 95-6000723, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Huntington Beach is willing to contribute approximately $2,292,744.47 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP, and DHCS on this issue:

Scott Haberle, Fire Chief
2000 Main Street, Huntington Beach, CA 92648
Office: 714-536-5401, Email: scott.haberle@surfcity-hb.org

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Scott M. Haberle

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Huntington Beach Paramedic Services, NPI 1568467264
County:	Orange County, CA
Health Plan:	Mcal HMO CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 2,786,447.41	$ 2,677,407.00	$ 493,702.94	$ 2,292,744.47	$ 2,183,704.06
Total	$ 2,786,447.41	$ 2,677,407.00	$ 493,702.94	$ 2,292,744.47	$ 2,183,704.06

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

We provide first responder, BLS, and full ALS 911 response and medical transport services to CalOptima patients with no contractual arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Huntington Beach

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The City of Huntington Beach general fund revenues.

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *N/A*

5. Comments / Notes

Charges and payment data were provided by Wittman Enterprises. Cost data was taken from a third-party consultant's 2020 fee study report (The Matrix Group) and isolated to CalOptima transports during the given date range using trip counts from Wittman Enterprises (9.9% or 1,401 out of 14,150 total transports).

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Scott Haberle, Fire Chief

Signature & Date: 6/24/2024

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NEWPORT BEACH FIRE DEPARTMENT

100 CIVIC CENTER DRIVE, P.O. BOX 1768, NEWPORT BEACH, CA 92660

PHONE: 949-644-3355 WEB: www.newportbeachca.gov

JEFF BOYLES
Fire Chief

June 20, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Newport Beach, a governmental entity, federal I.D. Number 956000751 in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Newport Beach is willing to contribute approximately $367,822 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kristin Thompson, EMS Division Chief: 100 Civic Center Drive, Newport Beach, CA 92660, kthompson@nbfd.net, (949)644-3385.

Raymund Reyes, Administrative Manager: 100 Civic Center Drive, Newport Beach, CA 92660, rreyes@nbfd.net, (949)644-3352.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Jeff Boyles
Fire Chief

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Newport Beach
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 705,523.45	$ 667,371.00	$ 134,955.38	$ 570,568.07	$ 532,415.62
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 705,523.45	$ 667,371.00	$ 134,955.38	$ 570,568.07	$ 532,415.62

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *YES*

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

All services provided to CalOptima members are on an oupatient basis and consist of emergency ambulance transportation services. These services are provided to the residents and visitors of Newport Beach on a non-contracted basis.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Newport Beach operating as the Fire Department

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City/Municipal Corporation

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The source of the IGT funds are estimated to be unrestricted General Fund monies from the City of Newport Beach

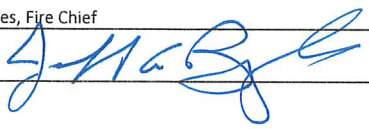
(iv) Does the transferring entity have general taxing authority? *YES*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *N/A*

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Jeff Boyles, Fire Chief

Signature & Date: 

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City of Orange

300 E. Chapman Ave.
Orange, CA 92866

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Orange, a governmental entity, federal I.D. Number 95-60007555, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Orange is willing to contribute approximately $579,294 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Bryan Johnson, EMS Manager
300 E. Chapman Ave. Orange, CA 92866
bjohnson@cityoforange.org
(714) 288-2503

Nathalia Flores, Administrative Analyst
300 E. Chapman Ave. Orange, CA 92866
nflores@cityoforange.org
(714) 288-2533

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Tom Kisela
City Manager

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Orange
County:	Orange
Health Plan:	CalOptima

Instructions
Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 1,675,657.22	$ 1,675,657.22	$ 341,620.60	$ 1,334,036.62	$ 1,334,036.62
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 1,675,657.22	$ 1,675,657.22	$ 341,620.60	$ 1,334,036.62	$ 1,334,036.62

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

911 dispatched emergency treatment and ground ambulance transport

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

City of Orange's unreserved general fund

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: Tom Kisela, City Manager

Signature & Date: [signature] 6/6/24

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VERONICA KELLEY, DSW, LCSW
AGENCY DIRECTOR

JASON AUSTIN, MA, LMFT
ASSISTANT AGENCY DIRECTOR

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

OFFICE OF THE DIRECTOR

June 20, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Attachment A-Letter of Interest for Voluntary Rate Range Program IGT 13

Dear Mr. Bishop:

This letter confirms the interest of County of Orange Health Care Agency, a governmental entity, federal I.D. Number 95-6000928, in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Pending approval by the Orange County Board of Supervisors, the County of Orange Health Care Agency is willing to contribute approximately **$3,547,480** for the Calendar Year 2023 (January 1, 2023 - December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Anza Vang
Assistant Deputy Director, Public Health Services
Orange County Health Care Agency
405 W. 5th Street, 7th Floor, Santa Ana, Ca 92701
(714) 615-6958

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I certify that I am authorized to sign this certification on behalf of the government entity and that the statements in this letter are true and correct.

Thank you for your consideration,

DocuSigned by:
Dr. Kelley
E8B80965A4EC417...

Veronica Kelley
Agency Director

CC: Jenna Sarin, Director of Public Health and Nursing
Anza Vang, Assistant Deputy Director, Public Health Services
Strategic Development, CalOptima Health

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	Orange County Health Care Agency
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 12,437,811.54	$ 6,007,006.80	$ 32,439.62	$ 12,405,371.92	$ 5,974,567.18
Total	$ 12,437,811.54	$ 6,007,006.80	$ 32,439.62	$ 12,405,371.92	$ 5,974,567.18

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***No***

If **No**, please specify the amount of funding available: $ 3,547,480.00

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

STD Clinic - Testing for sexually transmitted diseases (STD) including HIV. Treatment for STDs and linkage to care for individuals who test HIV-positive. Counseling and Prevention services for STDs and HIV.
TB Clinic - Diagnosis, treatment and case management for Orange County residents with tuberculosis (TB) disease.
Child Health Clinic - Sick child care, conducts developmental screening, and renders limited follow-up services for conditions found on the physical examination.
Medically High Risk Newborn Nursing Services - Public Health Nurse's (PHN) provide comprehensive case management services to medically fragile newborns and infants. A PHN assists parents/caregivers to help promote optimum growth and development in the infant; care for infants with special needs, and develop supportive family dynamic that promote attachment. Nurses provide continuing growth and developmental assessment, parental education and assistance in accessing necessary health services for high-risk infants.
Nurse Family Partnership (NFP) - NFP is an evidenced-based nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Nurse case managers improve the following: pregnancy outcomes, child health and development and economic self-sufficiency of the family.
Perinatal Substance Abuse Nursing Services - Public Health Nurses provide case management services for pregnant persons who have a history of substance use disorder, mental health issues, homelessness, and/or have HIV infection. PHN aide clients in gaining access to necessary health services and pediatric care during the client's pregnancy and through the first 6-12 month of the child's life. Services include, case management, education, coordination of care, and referrals to resources so mothers will have a healthy-drug free delivery and positive development environment for the infant.
Adolescent Family Life Program (ALFP) - Offers comprehensive case management services from social workers and licensed clinicians to expectant and parenting teens up to the age of 21 years and their children. Case managers work closely with youth to improve the health and well-being of themselves and their children providing support and linkage to services such as health services, mental health services, developmental, education, child care, transportation, financial aid, legal services, and parenting classes .

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: County of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)
Net County Cost and or Health Realignment

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Veronica Kelley, Orange County Healthcare Agency Director

Signature & Date: DocuSigned by: Dr. Kelley E8B80965A4EC417... 6/26/2024

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UCI Health

June 11, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services 1501
Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: UCI Health and CalOptima IGT 2023

Dear Mr. Bishop:

This letter confirms the interest of Regents of the University of California Irvine Medical Center, a governmental entity, federal I.D. Number 95-2226406, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Regents of University of California, Irvine Medical Center is willing to contribute approximately 89%of the total available for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Christopher M. Leo, Esq.
Director of Government Affairs
UCI Health
101 City Drive, Bldg. 53, Suite 100
Orange, CA 92868
cmleo@hs.uci.edu
(714) 456-2967

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Chad T. Lefteris, FACHE
President & Chief Executive Officer
UCI Health

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	University of California, Irvine Health
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient	$ 85,601,286.97	$ 64,157,276.35	$21,444,010.62	$ 64,157,276.35	$ 42,713,265.73
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$87,424,867.91	$ 65,946,999.12	$21,477,868.79	$ 65,946,999.12	$ 44,469,130.33
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 173,026,154.88	$ 130,104,275.47	$ 42,921,879.41	$ 130,104,275.47	$ 87,182,396.06

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***Yes***

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

Yes, services are provided under contract arrangement. Inpatient and outpatient (including emergency services) medical services at UC Irvine Health are provided by UPS physicians. Physician medical specialty care includes those services considered tertiary and quaternary. UPS physician services are made available to CalOptima members through provider agreements between UPS and CalOptima.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: UCI University Physicians & Surgeons (UPS)

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: Governmental Funding Entitiy

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Patient care revenue

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Chad T. Lefteris, President & Chief Executive Officer

Signature & Date: 6/11/24

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Voluntary Rate Range Program
Attachment C
January 1, 2023 - December 31, 2023

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 23 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,472,048	99.09	$ 106.27	$ 7.18	$ -	$ 7.18	$ 24,929,305	$ 10,525,551	42.22%
506	CalOptima	Orange	Child	UIS	148,873	32.09	$ 34.73	$ 2.64	$ -	$ 2.64	$ 393,025	$ 177,141	45.07%
506	CalOptima	Orange	Adult	SIS	1,423,569	212.50	$ 225.70	$ 13.20	$ -	$ 13.20	$ 18,791,110	$ 8,573,220	45.62%
506	CalOptima	Orange	Adult	UIS	267,683	178.51	$ 189.06	$ 10.55	$ -	$ 10.55	$ 2,824,056	$ 1,254,778	44.43%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,773,376	304.58	$ 322.43	$ 17.85	$ 4.46	$ 13.39	$ 50,525,505	$ 5,052,550	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	419,435	292.09	$ 308.77	$ 16.68	$ 4.17	$ 12.51	$ 5,247,132	$ 575,180	10.96%
506	CalOptima	Orange	SPD	SIS	442,469	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 20,397,821	$ 9,515,885	46.65%
506	CalOptima	Orange	SPD	UIS	86,182	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 3,595,513	$ 1,661,790	46.22%
506	CalOptima	Orange	SPD/Full-Dual	SIS	1,299,679	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 20,807,861	$ 9,720,739	46.72%
506	CalOptima	Orange	SPD/Full-Dual	UIS	6,355	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 44,104	$ 20,604	46.72%
506	CalOptima	Orange	LTC	SIS	2,597	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 119,722	$ 55,930	46.72%
506	CalOptima	Orange	LTC	UIS	1,559	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 65,041	$ 30,381	46.71%
506	CalOptima	Orange	LTC/Full-Dual	SIS	31,893	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 510,607	$ 238,539	46.72%
506	CalOptima	Orange	LTC/Full-Dual	UIS	124	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 861	$ 402	46.69%
506	CalOptima	Orange	Whole Child Model	SIS	133,436	1,761.91	$ 1,852.98	$ 91.07	$ -	$ 91.07	$ 12,152,017	$ 5,094,006	41.92%
506	CalOptima	Orange	Whole Child Model	UIS	4,171	552.77	$ 583.55	$ 30.78	$ -	$ 30.78	$ 128,383	$ 54,716	42.62%
506	**CalOptima**	**Orange**	**All COAs**		**11,513,449**	**287.15**	**$ 302.71**	**$ 15.56**	**$ 8.63**	**$ 13.94**	**$ 160,532,063**	**$ 52,551,412**	**32.74%**

Footnotes:
1 The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 23 MM effective as of March 2024.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Actions Related to a Contract with the National Opinion Research Center to Conduct a Member and Population Health Needs Assessment

Contact

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

Recommended Actions

Pursuant to the result of a formal procurement process, authorize the Chief Executive Officer to execute a contract with the National Opinion Research Center for a one-year term effective March 14, 2025, to conduct a Member and Population Health Needs Assessment.

Background

Following CalOptima Health's approval of the Harder + Company contract to perform a refreshed Member Health Needs Assessment in 2023, new regulatory and accreditation requirements from the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. This resulted in termination of the contract with Harder + Company to develop a new scope of work (SOW) and project approach.

On April 4, 2024, the Board authorized the reallocation of $1 million in unspent appropriated funds to conduct a refreshed Member and Population Health Needs Assessment (MPHNA). The Board approved a new SOW to include the new requirements along with the release of a request for proposal (RFP) to procure the services of a research consultant.

On June 24, 2024, CalOptima Health completed the RFP process and received a total of six (6) proposals. However, given the changes to DHCS requirements related to CalAIM and Community Reinvestment, staff further identified a need to understand community assets to ensure alignment and partnership opportunities in community development work and investment strategies. This resulted in extending the timeline to develop a comprehensive list of requirements for the RFP. The prior RFP was canceled on August 1, 2024, and a revised RFP was issued on December 9, 2024.

Discussion

The MPHNA RFP issued on December 9, 2024, requested services to:

1. Assess the whole-person health needs and preferences of CalOptima Health members;
2. Assess community assets to inform the development of health equity interventions and community investments;
3. Provide best practices to develop programs and strategic approaches that best serve all Orange County Medi-Cal members; and
4. Assist with developing the Medi-Cal Population Needs Assessment and the NCQA Health Plan Accreditation and Health Equity Accreditation member assessments.

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The SOW requested in the RFP included the following required deliverables:

1. Study design to identify, synthesize, and analyze all available data to assess member health and population needs.
2. Detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities.
3. Final survey instruments (*e.g.*, member, provider, key informant), focus group facilitation guides, presentations, and other relevant materials.
4. Member outreach and engagement activities in threshold languages as needed to support the approved study design.
5. Data set collected and synthesized through the conduct of the assessment study.
6. Health Equity Asset Maps (HEAM), digital mapping tools that provide clear and engaging visualizations and visual aids of community assets in Orange County.
7. Analysis highlighting key initiatives and projects in the community and their organizations, assessing potential alignment and partnership opportunities with CalOptima in community development work and investment strategies.
8. MPHNA and HEAM reports and executive summary presentations detailing assessment findings and recommendations.
9. Interactive dashboard for ongoing population needs assessment and heat asset mapping reporting.

The RFP closed on January 21, 2025, and CalOptima Health received a total of eleven (11) proposals. All proposals were reviewed by an evaluation committee of CalOptima Health staff based on the following criteria:

- Demonstrated understanding and knowledge of the population health needs of Medi-Cal, Medicare, Orange County, and vulnerable populations;
- Proposed study design and methodology;
- Demonstrated knowledge and experience with data collection and analysis;
- Demonstrated understanding of the importance and role of comprehensive assessment of member needs to inform targeted Medi-Cal Managed Care Plan interventions;
- Demonstrated experience with engaging members and conducting member outreach and/or focus groups;
- Demonstrated experience with health equity asset mapping to provide information about the strengths and resources of a community;
- Qualifications and experience of the proposer and proposed team;
- Proposed approach and schedule; and
- Differentiators of the project design.

Proposal

Upon completing the proposal evaluation process, the following scores were given to each applicant:

Name	Proposal Score	Rank
Health Management Associates (HMA)	88.2	1
National Opinion Research Center (NORC)	87.4	2
Charitable Ventures of Orange County, Inc	76.6	3
Advance OC	76.5	4
COPE Healthcare Consulting, Inc. dba COPE Solutions Academy	69.6	5
Eviset, Inc	68	6
Sellers, Dorsey & Associates, LLC	66.2	7
Orange County Asian and Pacific Islander Community Alliance, Inc	61.2	8
ZS Associates, Inc	59	9
Measurement Resource Company	48.2	10
ECG Management Consultants LLC	44.2	11

Final Score After Interviews

The evaluation committee extended interviews to the organizations with the top two highest-scoring proposals, with the following final scores given to the applicants:

Name	Final Score	Rank
National Opinion Research Center (NORC)	90.5	1
Health Management Associates (HMA)	82.5	2

Based on standard procurement processes and in accordance with CalOptima Health Policy GA.5002: Purchasing, the evaluation team identified the NORC as the vendor that best meets CalOptima Health needs.

The targeted effective date of the new contract with NORC will be March 14, 2025. The contract will be for a one (1)-year term with a one (1) year extension option, exercisable at CalOptima Health's sole discretion.

Fiscal Impact

The recommended action will not have an additional fiscal impact. A previous Board action on April 4, 2024, reallocated $1 million from the Board-approved initiative CalOptima Health 2023 MHNA to fund the 2024 MPHNA. This funding will be sufficient to cover the estimated one-year cost for the contract with NORC of $966,384.

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Rationale for Recommendation

Based on the evaluation results of the eleven (11) proposals received, staff recommend contracting with NORC as the vendor that best meets CalOptima Health's objectives for conducting a MPHNA and Health Equity Mapping initiative.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action.
2. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."
3. Previous Board Action April 4, 2024, "Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment."

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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Attachment to the March 6, 2025 Board of Directors Meeting – Agenda Item 10

Attachment #1 Member and Population Health Needs Assessment Contract

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The National Opinion Research Center (NORC)	55 East Monroe St, 30th Floor	Chicago	IL	60603

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment

Contact

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

Recommended Actions

1. Authorize reallocation of remaining unspent funds, approximately $1.0 million, from the Board-approved initiative CalOptima Health 2023 Member Health Needs Assessment (MHNA) to fund the 2024 Member and Population Health Needs Assessment (MPHNA).
2. Approve the scope of work (SOW) for the 2024 CalOptima Health MPHNA and release of a request for proposals (RFP).

Background

In 2018, CalOptima Health conducted a Member Health Needs Assessment (MHNA) to identify the focused needs of Orange County's Medi-Cal beneficiaries, in particular to assess the health needs and preferences of diverse populations. The results of the 2018 assessment highlighted key findings in the areas of:

- Social Determinants of Health,
- Mental Health,
- Primary Care,
- Provider Access, and
- Dental Care.

On November 3, 2022, the CalOptima Health Board of Directors (Board) approved $1 million from reserves to fund the CalOptima Health 2023 MHNA to conduct an expanded and refreshed assessment and to take into account the needs of members after the COVID-19 pandemic. CalOptima Health released an RFP for consultant services on November 8, 2022, and the evaluation committee selected Harder + Company Community Research (Harder + Company) to conduct the assessment. On February 2, 2023, the Board approved the contract with Harder + Company in an amount not to exceed $1,250,000 and appropriated up to $250,000 from reserves to fund the shortfall. The contract was to assess and support the following areas:

- Implementing Department of Health Care Services (DHCS) population health strategies (*e.g.*, population health management strategy, support health and opportunity for children and families, comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (now referred to as Medi-Cal Transformation) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.

- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by the COVID-19 pandemic and identifying sustainable solutions.

Following approval of the Harder + Company contract in 2023, new regulatory and accreditation requirements from DHCS and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. As CalOptima Health began working with Harder + Company, CalOptima Health staff discovered that these new requirements were not accounted for in the Board approved SOW and contract. Based on the new changes to regulatory and accreditation requirements, CalOptima Health staff chose to end the Harder + Company contract in January 2024 and develop a new SOW and project approach.

Discussion

Given the changes to regulatory requirements under Medi-Cal Transformation and NCQA accreditation requirements, staff recommends Board approval of the new SOW and release of an RFP to procure the services of a research consultant with knowledge of Orange County's diverse populations and opportunities for meaningful outreach and engagement to conduct the 2024 MPHNA. The new MPHNA will be a more comprehensive assessment and will be expanded to help CalOptima Health assess whole-person health needs and identify additional barriers to access to care, gaps in services, and disparities in health among members and the general community. The 2024 MPHNA will utilize existing CalOptima Health member data, existing community data provided by the county Community Health Needs Assessment, and other sources of data. The 2024 MPHNA may also utilize a small member survey and member focus groups to obtain member input.

There is approximately $1.0 million in unspent funds available for reallocation after the termination of the Harder + Company contract. Staff recommends reallocation of the remaining funds to support the CalOptima Health 2024 MPHNA. If approved, CalOptima Health will issue an RFP for consultant services for the new SOW. Proposals received will be evaluated by an evaluation committee. Upon completion of the RFP process, staff will make a recommendation for selection of a vendor to the Board at a future Board meeting.

Fiscal Impact

Previous Board actions on November 3, 2022, and February 2, 2023, authorized $1.25 million to fund the CalOptima Health 2023 MHNA. The remaining unspent funds of approximately $1.0 million committed for this Board-approved initiative will fund the CalOptima Health 2024 MPHNA.

Rationale for Recommendation

Approving the recommended actions will allow CalOptima Health to move forward with a new SOW and obtain a contractor that can support all regulatory and accreditation requirements for member and population assessment.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed CalOptima Health Member and Population Health Needs Assessment (MPHNA) 2024 Scope of Work.
2. Previous Board Action November 3, 2022, "Approve Actions Related to CalOptima Health Member Health Needs Assessment 2023."
3. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

SCOPE OF WORK
CalOptima Health Member and Population Health Needs Assessment

I. OBJECTIVE

CalOptima Health is seeking a contractor to conduct a comprehensive Member and Population Health Needs Assessment (MPHNA). The purpose of the MPHNA is to:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

II. SCOPE OF WORK

CalOptima Health seeks a contractor to provide professional research and analytical services that has detailed knowledge of Medi-Cal, Medicare, and Orange County populations. The contractor shall have demonstrated expertise and knowledge in analyzing population and member level data and producing detailed analyses and dashboards to present study findings. The contractor shall be able to analyze existing CalOptima Health and community data sources and also propose approaches to obtaining member, provider, and community input through interviews, surveys and/or focus groups.

Consulting services will be for the purpose of taking a strategic approach to consolidating related CalOptima Health efforts to assess population health data (including members and potential members) that meets deliverable requirements as outlined by the Department of Health Care Services (DHCS), NCQA, and other related requirements. These contracted services will inform and support CalOptima Health in achieving the following objectives:

- Meet the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, Population Needs Assessment (PNA), and Medi-Cal Transformation initiatives.
- Meet the requirements of NCQA Health Plan Accreditation PHM Standards, PHM 2, including Elements A (Data Integration), B (Population Assessment), and D (Segmentation).
- Meet the requirements of NCQA Health Equity Accreditation as applicable.
- Understand the detailed member and population needs of our member population and community, including in the domains outlined in this scope of work.

- Understand member experience with CalOptima Health services and recommendations for future service offerings.
- Identify opportunities to advance health equity with our member population.

The MPHNA areas of assessment will include *but not be limited to* the attributes/domains of the CalOptima Health member population as outlined in the table below. CalOptima Health aims to assess these areas for our entire member population as well as for subsets of the member population, including child and adolescent members, members with disabilities, members with serious mental illness or serious emotional disturbance, members of racial or ethnic groups, members with limited English proficiency, and other relevant subpopulations.

Assessment Domain	Areas for Analysis
Demographics of Member Population	• Age • Race • Ethnicity • Language • Sexual Orientation • Gender Identity • Etc.
Health Status and Health Conditions	• Chronic conditions/disease prevalence (e.g., asthma, diabetes, chronic obstructive pulmonary disease, etc.) • Member risk profile • Births • High-risk pregnancy • Behavioral health conditions • Smoking • Substance use disorder • Disparities • Vaccination rates • Select Healthcare Effectiveness Data and Information Set (HEDIS) measures
Social Conditions	• Social determinants of health needs • Barriers to getting needed help • Barriers to economic mobility • Transportation challenges • Etc.
Health Equity	• Challenges with accessing care (e.g., language, health literacy, affinity with providers, etc.) • Challenges with accessing social supports • Member experience • Cultural preferences

Assessment Domain	Areas for Analysis
Access to Care and Supports	• Barriers to accessing care and support (e.g., childcare, hours of operation, not enough information, unable to find a provider, no appointments available/delays in timely access, etc.) • Access to behavioral health services and barriers • Services most and least utilized • Unmet care needs • Eligibility loss/churn/income changes
CalOptima Health Services & Supports	• Experience with CalAIM services • Medicare supplemental benefits • Participation in other coverage programs • How CalOptima Health partners in their communities

The project shall incorporate coordination and collaboration with CalOptima Health and external partners (e.g., Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

III. CONSULTANT/CONTRACTOR'S RESPONSIBILITIES

Consultant/Contractor shall:

1. Develop a study design to identify, synthesize, and analyze all available data to assess member health and population needs, including but not limited to:
    a. CalOptima Health internal data
    b. Additional data sources, i.e., the county Community Health Needs Assessment, etc.
    c. Member input through a small-scale member survey to fill gaps in existing data, focus groups, etc.
    d. Community input
    e. Provider input

    The Study design must outline study methodologies, data sources, and data collection methods. The study design must be presented to CalOptima Health for review and input prior to finalization. It will also be presented to the CalOptima Health Member and Provider Advisory Committee and potentially other community forums for comment.

2. Develop a detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities. The timeline should be developed in partnership with CalOptima Health staff to account for regulatory approval timelines where necessary. The project plan must be updated throughout the project if timelines change.

3. Develop MPHNA deliverables that will be presented to CalOptima Health for review and approval, including if applicable:
    a. Final survey instruments (e.g., member, provider, key informant)
    b. Focus group facilitation guides, presentations, and other relevant materials
    c. Outreach and engagement materials for member communication and community organization communication

    All member facing materials must be translated in all threshold languages. All member facing materials must also be submitted for review to CalOptima Health. CalOptima Health may be required to submit certain materials to the Department of Health Care Services for review and approval, and timelines should be constructed to allow such approval time.

4. Facilitate member outreach and engagement activities in threshold languages in partnership with CalOptima Health and community organizations (e.g. member incentives, focus groups, community, or member forums, etc.) as needed to support the approved study design.

5. Provide interim assessment deliverables for NCQA filings if needed. These interim deliverables may include a preliminary assessment of internal and secondary data sources and obtaining member input from existing member committees and forums.

6. Develop final MPHNA report and executive summary presentation to CalOptima Health and its leadership detailing assessment findings and recommendations.

7. Produce dashboard for member assessment that can be utilized by CalOptima Health staff and stakeholders for ongoing population needs assessment reporting.

8. Deliver data set collected and synthesized through the conduct of the assessment study.

9. Schedule and conduct regular meetings with CalOptima Health staff to present relevant findings and project status.

10. Present MPHNA findings to the CalOptima Health Board of Directors.

The Consultant/Contractor must perform all work according to industry and professional standards and in a manner satisfactory to CalOptima Health and, if applicable, regulatory and accreditation requirements.

The Consultant/Contractor may propose to utilize subcontracted services for survey administration and/or focus group facilitation to ensure alignment of skills with services. The Consultant/Contractor is responsible for ensuring that performance and completion of project deliverables by any and all subcontractors align with the responsibilities outlined in this scope of work.

IV. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health staff shall:

1. Provide a point of contact and meet regularly with the Consultant/Contractor to discuss project status, open questions, and deliverable development.
2. Provide documentation on requirements for Consultant/Contractor to review and key resources and department point of contacts.
3. Provide guidance on regulatory and CalOptima Health's requirements.
4. Work collaboratively with Consultant/Contractor to promote member and provider surveys, if included in the study design.
5. Provide and distribute Member Incentives (if applicable).
6. Utilize existing community relationships to make introductions for the Consultant/Contractor to connect with these organizations.
7. Facilitate CalOptima Health internal approvals and DHCS regulatory approvals as needed.
8. Provide Consultant/Contractor with points of contact to administer community leader/key informant and provider interviews (if applicable).

V. TIMELINES

This contract will continue through the completion of deliverables outlined in the Scope of Work, with a framework that can be leveraged for annual refreshing on a go-forward basis of the MPHNA to meet NCQA requirements. Consultant/Contractor shall:

1. Begin project planning in July 2024, with implementation through December 2024.
2. On an ongoing basis, meet regularly with CalOptima Health to assess progress and opportunities and share findings with CalOptima Health.

VI. PRICING

The Consultant/Contractor should propose a budget and pricing for this project.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

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comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

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SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Ratify a Sole Source Contract with Axis Technology for Data Masking Professional Services

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Ratify a sole source contract with Axis Technology for a term beginning February 25, 2025, through December 31, 2026, for data masking of CalOptima Health databases that contain protected health information and personally identifiable information, in accordance with CalOptima Health Policy GA.5002: Purchasing Policy.

Background and Discussion

In November 2023, CalOptima Health began a project to mask sensitive information in databases to eliminate data privacy risks and comply with regulatory requirements. CalOptima Health contracted with Axis Technology to provide professional services for this project, which included designing the process and workflow for data masking, assessment of each database for sensitive data that requires masking, development of operating procedures for each database and training for use post masking, and implementation of virtual databases using CalOptima's selected tool. CalOptima Health contracted with Axis Technology under the small purchases provision of GA.5002: Purchasing Policy, which allowed awarding of contracts valued between $50,000 and $250,000 per vendor per fiscal year after obtaining at least two informal bids or quotations from known suppliers. The data masking project qualified as a small purchase under this policy as the estimated cost was under $250,000 per fiscal year.

In May 2024, CalOptima Health's Board of Directors (Board) approved revisions to CalOptima Health Policy GA.5002: Purchasing Policy. Under the revised policy, a small purchase is defined as purchases between $50,000 and $250,000 in total, for the life of that contract. However, the policy also permits the procurement of goods and services through sole source contracting without competitive bidding when goods or services are additions to a critical system already procured from the vendor or must conform to or become part of existing products or equipment.

If CalOptima Health were to competitively bid the project at this time, the project risks losing the work already completed, delays as a new vendor, if agreeable, learns the processes and workflows already implemented, and increased costs associated with changing vendors. Given that the data masking project is in flight and 20% complete, staff executed the sole source contract with Axis Technology on February 25, 2025, and request the Board ratify the contract. CalOptima Health will start a formal procurement in early 2026 for vendor services to maintain ongoing data masking of protected health information and personally identifiable information in CalOptima Health databases.

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Fiscal Impact

The estimated cost of the Axis Technology contract for the period of February 25, 2025, through December 31, 2026, is $410,000. The current year fiscal impact for the period of February 25, 2025, through June 30, 2025, is included in the Fiscal Year 2024-25 Digital Transformation Administrative Budget. Management will include expenses for the period on and after July 1, 2025, in future operating budgets.

Rationale for Recommendation

The recommended action will ensure that CalOptima Health completes the data masking project on schedule to protect sensitive data and to comply with regulatory requirements. Using the existing vendor will allow the project to stay on schedule, will avoid any duplication in efforts of the work already completed, and will avoid cost increases associated with changing vendors.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Contract with Axis Technology, LLC
2. Entities Covered by this Recommended Action

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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CONTRACT NO. 25-01090 ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("**CalOptima**")
And
AXIS TECHNOLOGY, LLC
("**Contractor**")

This Contract is made and entered into as of the date last signed below ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**") and Axis Technology, LLC, a Delaware limited liability company, hereinafter referred to as "**Contractor**." CalOptima and Contractor may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide Data Masking Professional Services, as described in the Scope of Work in Exhibit A;

B. Contractor provides such services;

C. Contractor represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. Contractor desires to perform these services for CalOptima; and

E. CalOptima and Contractor desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii)Contractor's quote dated February 18, 2025("**Proposal**"). Any new terms and conditions attached to Contractor's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

   2.1 Contractor shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1 At Contractor's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, Contractor shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. Contractor shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, Contractor shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for Contractor. Contractor's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of Contractor, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to Contractor's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the Contractor's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the Contractor's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

3.2.3 Contractor's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the Contractor for CalOptima. This provision applies to the Contractor's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 Contractor shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the Contractor to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the Contractor and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If Contractor maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If Contractor fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to Contractor. Such termination shall not affect Contractor's right to be paid for its time and materials expended prior to notification of termination. Contractor waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 Contractor shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "CalOptima Indemnified Parties") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', gross negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the CalOptima Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards; provided, that that: (i) CalOptima notifies CONTRACTOR in writing within fifteen (15) days of CalOptima becoming aware of the claim; provided that CalOptima's failure to so notify CONTRACTOR shall not relieve CONTRACTOR of any of its indemnification obligations unless such failure materially and adversely affects CONTRACTOR's ability to investigate and defend such claim; (ii) CONTRACTOR has sole control of the defense and all related settlement negotiations; provided, that CONTRACTOR may not settle any such claim in a manner that imposes any unreasonable restrictions or obligations on CalOptima without CalOptima's prior written consent; and (iii) CalOptima provides CONTRACTOR with the assistance, information and authority necessary to perform CONTRACTOR's obligations under this section. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.2 To the fullest extent permitted by law, CalOptima shall defend, indemnify, and hold harmless CONTRACTOR and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Contractor Indemnified Parties") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out CalOptima's, or its officers, employees, subcontractors, agents, or representatives', gross negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CONTRACTOR. CalOptima shall defend the Contractor Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards; provided, that that: (i) CONTRACTOR notifies CalOptima in writing within fifteen (15) days of CONTRACTOR becoming aware of the claim; provided that CONTRACTOR's failure to so notify CalOptima shall not relieve CalOptima of any of its indemnification obligations unless such failure materially and adversely affects CalOptima's ability to investigate and defend such claim; (ii) CalOptima has sole control of the defense and all related settlement negotiations; provided, that CalOptima may not settle any such

claim in a manner that imposes any unreasonable restrictions or obligations on CONTRACTOR without CONTRACTOR's prior written consent; and (iii) CONTRACTOR provides CalOptima with the assistance, information and authority necessary to perform CalOptima's obligations under this section. CONTRACTOR may make all reasonable decisions with respect to its representation in any legal proceeding. CalOptima's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CalOptima, save and except claims arising through the sole negligence or sole willful misconduct of CONTRACTOR.

4.3 Each Party's obligation to indemnify hereunder is in addition to any liability such Party may have to the other Party for a breach by such Party of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit Contractor's indemnification and duty to defend obligation or other liability hereunder

4.4 Each Party's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq.*).

4.5 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.6 The terms of this Section 4 shall survive the termination of this Contract.

4.7 LIMITATION ON LIABILITY. NEITHER PARTY SHALL HAVE ANY LIABILITY UNDER THIS CONTRACT FOR ANY INCIDENTAL, CONSEQUENTIAL, SPECIAL, PUNITIVE OR INDIRECT DAMAGES OR LIABILITIES, INCLUDING SUCH DAMAGES OR LIABILITIES FOR LOSS OF REVENUE, LOSS OF BUSINESS, FRUSTRATION OF ECONOMIC OR BUSINESS EXPECTATIONS, WORK DELAYS, LOSS OF PROFITS, OR COST OF CAPITAL, REGARDLESS OF THE FORM OF THE ACTION, WHETHER IN CONTRACT OR OTHERWISE, EVEN IF A PARTY HERETO HAS BEEN ADVISED, KNOWS, OR SHOULD HAVE KNOWN OF THE POSSIBILITY OF SUCH DAMAGES; PROVIDED, HOWEVER, THAT THE LIMITATION ON LOST PROFITS SHALL NOT APPLY TO EITHER PARTY'S LIABILITY, IF ANY, FOR EXCEEDING THE SCOPE OF ANY LICENSES GRANTED TO SUCH PARTY BY THE OTHER PARTY AND THAT NO LIMITATION SHALL APPLY TO EITHER PARTY'S LIABILITY, IF ANY, FOR A BREACH OF ITS CONFIDENTIALITY OR INDEMNIFICATION OBLIGATIONS HEREUNDER.

EXCEPT WITH RESPECT TO CONTRACTOR'S BREACH OF ITS OBLIGATIONS UNDER SECTION 8 OR EXHIBIT H AND ITS INDEMNITY OBLIGATIONS SET FORTH IN THIS SECTION 4, CONTRACTOR'S LIABILITY FOR DAMAGES TO CALOPTIMA FOR ANY CAUSE WHATSOEVER, REGARDLESS OF THE FORM OF ANY CLAIM OR ACTION, SHALL NOT EXCEED TWO MILLION DOLLARS ($2,000,000).

THE LIMITATION ON CONTRACTOR'S LIABILITY IS CUMULATIVE, WITH ALL PAYMENTS TO CALOPTIMA FOR CLAIMS OR DAMAGES UNDER THIS CONTRACT BEING AGGREGATED TO DETERMINE SATISFACTION OF THE LIMIT. THE EXISTENCE OF ONE OR MORE CLAIMS OR SUITS WILL NOT ENLARGE THE LIMIT. THESE LIMITATIONS APPLY TO ALL CAUSES OF ACTION UNDER OR RELATING TO THIS AGREEMENT (CONTRACT, TORT OR OTHERWISE).

5. Independent Contractor. CalOptima and Contractor agree that Contractor, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the Contractor, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. Contractor's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. Contractor's personnel performing services under this Contract shall be at all times under Contractor's exclusive direction and control and shall be employees of Contractor and not employees of CalOptima. Contractor shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. Contractor shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 Contractor Staffing. Contractor shall ensure that only fully qualified Contractor personnel are assigned to perform the services under the Contract, and such Contractor personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 Contractor Personnel Restrictions. When on CalOptima's premises, Contractor personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by Contractor, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by Contractor at no cost to CalOptima.

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and Contractor agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

7.2 CalOptima will not reimburse Contractor any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

7.3 Contractor's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract, including in Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY Contractor IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4 In no event shall the total compensation payable to Contractor for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **Contractor ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

7.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. Contractor is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to Contractor due to Contractor's failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq.*, applicable provisions of California Welfare and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 Contractor shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of Contractor. Those security procedures and other safeguards shall be no less rigorous than those maintained by Contractor for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return

materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 For the purposes of Section 8.6 only, Confidential Information does not include protected health information ("**PHI**") or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other privacy statutes or regulations. The access use and disclosure of PHI shall be governed by a BAA, which is Exhibit H to this Contract.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq.*) (the "**PRA**"). Contractor hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by Contractor. If Contractor discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless Contractor marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that Contractor has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any Contractor's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses Contractor materials that have been properly marked, CalOptima will provide Contractor with notice thereof to allow Contractor to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, Contractor shall notify CalOptima if it intends to object to production of Contractor's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. Contractor agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought Contractor's marked material, arising out of or related to CalOptima's failure to produce or provide the Contractor-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). Contractor shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to Contractor at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and Contractor. Execution of amendments shall be contingent upon Contractor's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for Contractor's performance.

11. Assignments.

11.1 Contractor may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, Contractor acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in Contractor (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of Contractor (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of Contractor with another entity with respect to which Contractor is not the surviving entity; and/or (4) a change in the management of Contractor from management by persons appointed, elected or otherwise selected by the governing body of Contractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. Contractor may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through 2/24/2026 ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving Contractor forty-five (45) days' prior written notice. Upon termination, CalOptima shall pay Contractor all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, Contractor shall have no further claims against CalOptima under this Contract.

14.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay Contractor all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Contractor shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to Contractor for (i) Contractor's bankruptcy, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against Contractor; or (iii) if Contractor makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach, provided that the non-breaching party may terminate the Contract immediately upon written notice if the non-breaching Party reasonably determines that cure of the default within thirty (30) days is impossible. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon Contractor's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 Contractor shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by Contractor in performing this Contract, whether completed or in process. If Contractor personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

14.6.3 In the event of termination under Sections 14..3, 14.4, or 14.5, either Party shall be liable for any and all reasonable costs incurred by the non-breaching Party as a result of such a termination.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq.*) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and Contractor. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. Contractor warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to Contractor on CalOptima's website.

16.3 Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of 30 days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To Contractor:	**To CalOptima Health:**
Axis Technology, LLC	CalOptima Health
50 Milk Street, 16th Fl	505 City Parkway West
Boston MA 02109	Orange, CA 92868
Attention: Legal	Attention: Lisa Ha
Email: legal@axistechnologyllc.com	Email: lisaha@caloptima.org

16.8 Notice of Labor Disputes. Whenever Contractor has knowledge that any actual or potential labor dispute may delay this Contract, Contractor shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between Contractor and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between Contractor and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 25-01090 on the day and year last shown below.

Axis Technology, LLC	CalOptima Health
By: DocuSigned by: George L. Barroso B98467BAD7CF48E...	By: Signed by: Michael Hunn EDDDDCC19C894FB...
Print Name: George L. Barroso	Print Name: Michael Hunn
Title: Vice President, Data Solutions Date: 2/20/2025	Title: CEO Date: 02/25/2025

By: Signed by: Michael J. Logan 2D47C7674B764E0...	By: Signed by: Nancy Huang D22E3B87032946F...
Print Name: Mike Logan	Print Name: Nancy Huang
Title: CEO Date: 2/20/2025	Title: CFO, CalOptima Date: 02/24/2025

EXHIBIT A
Scope of Work

1. **Description of Work**

1.1. OBJECTIVE:
CONTRACTOR will proficiently mask sensitive information in our nonproduction databases using Delphix Continuous Compliance and Continuous Data tools. CONTRACTOR has established an approach to create a complete Data Privacy solution to eliminate data privacy risk at the company. The implementation should provide CalOptima automation, integration, and orchestration services to reduce manual effort and integrate the Delphix platform into the existing DevOps pipeline.

1.2. SCOPE OF WORK
- 1.2.1. Onboard 80 databases and 80 file formats
  - 1.2.1.1. Define databases onboarded with client.
  - 1.2.1.2. Create application data flows that involve data masking.
  - 1.2.1.3. Define the number of fields that need to be obfuscated for the in-scope databases.
  - 1.2.1.4. Define number and frequency of masking refreshes.
  - 1.2.1.5. Leverage custom algorithms from Axis Data Privacy Accelerator as required.
  - 1.2.1.6. Obfuscate sensitive data in the target databases.
  - 1.2.1.7. Support testing issues due to masking.
  - 1.2.1.8. Complete testing till client signoff.
  - 1.2.1.9. Create a go-live plan.
  - 1.2.1.10. Document accomplishment and lesson learned.
  - 1.2.1.11. Define metrics for reporting.
- 1.2.2. Automate for Delphix onboarding processes
  - 1.2.2.1. Design of automation for Operational Masking processes
    - 1.2.2.1.1. Chaining all of the following together:
      - 1.2.2.1.1.1. Execution of Schema Recon
      - 1.2.2.1.1.2. Execution of Updating Inventory
      - 1.2.2.1.1.3. Execution of Running Masking Jobs
  - 1.2.2.2. Design of automation for Operational Virtualization processes
    - 1.2.2.2.1. Chaining all of the following together:
      - 1.2.2.2.1.1. Execution of a data cut refresh
      - 1.2.2.2.1.2. Execution of Masking process
      - 1.2.2.2.1.3. Execution of Taking a snapshot
      - 1.2.2.2.1.4. Execution of Replicating data downstream
      - 1.2.2.2.1.5. Execution of Refreshing downstream template
      - 1.2.2.2.1.6. Execution of Taking a bookmark on template VDB
  - 1.2.2.3. Implementation of automation for Operational Masking processes determined from design
  - 1.2.2.4. Implementation of automation for Operational Virtualization processes determined from design

2. **Standard of Performance; Warranties.**

2.1 Contractor agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If Contractor may subcontract for services under this Contract, then Contractor represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 Contractor expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. Contractor further warrants that all material covered by this Contract, if any, which is the product of Contractor will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to Contractor. Contractor shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to Contractor of any observed defects. If Contractor fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge Contractor the costs incurred.

2.4 Contractor's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 Contractor's obligations under this Section 2 are in addition to Contractor's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against Contractor for faulty materials, equipment or work. CalOptima rejects any disclaimer by Contractor of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by Contractor, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by Contractor at no cost to CalOptima.

3. **Record Ownership and Retention.**

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for Contractor's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. Contractor shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 Contractor hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter Contractor created in these Works. Contractor agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, Contractor will return or transfer all property and materials, including the Works, in Contractor's possession or control belonging to CalOptima.

4. **Required Insurance**

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

4.2. If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3. Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of Contractor's employees:

4.3.1. The policy must provide statutory coverage for Worker's Compensation.

4.3.2. The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4. Professional Liability insurance covering the Contractor's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate.

4.5. Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

4.6. Cyber Liability insurance with the minimum limits of insurance listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

4.6.1. One Million ($1,000,00.00) each occurrence/claim and One Million ($1,000,00.00) aggregate.

4.7. "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

EXHIBIT B
Payment

1. For Contractor's full and complete performance of its obligations under this Contract, CalOptima shall pay Contractor for fees and expenses in accordance with the provisions of this Exhibit B and subject to the maximum cumulative payment obligations specified below.

2. Contractor shall invoice CalOptima on a monthly basis for actual labor hours expended. The hourly rates, as defined below, are acknowledged to include Contractor's base labor rates, overhead and profit. Work completed shall be documented in a monthly progress report prepared by Contractor, which report shall accompany each invoice submitted by Contractor. Contractor shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as Contractor has documented, to CalOptima's satisfaction, that Contractor has fully completed all work required under this Contract and Contractor's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of Contractor's work under this Contract.

3. Contractor shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 25-01090; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and Contractor mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Four Hundred and Ten Thousand Dollars ($410,000.00), including all amounts payable to Contractor for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

5. Contractor's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the milestone payment table below. For any additional work beyond that specified in Exhibit A, Scope of Work, that is authorized by CalOptima in a written amendment or change order. Contractor agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay Contractor for time spent traveling.

Description	QTY	Price
Delphix Masking Implementation Package 80 databases and 80 file formats	1	$350,000.00
Automation for Delphix Masking/Virtualization Onboarding Automation of end-to-end onboarding process for Delphix Masking/Virtualization	1	$60,000.00

Milestone Payments

Item	Milestone	Amount
Milestone #1	Execution of this SOW	$105,000.00
Milestone #2	Axis Data Privacy Accelerator 1 Year Subscription	$25,000.00

Milestone #3	Upon masking of 50% of in-scope databases	$110,000.00
Milestone #4	Upon masking of remaining in-scope databases	$110,000.00
Milestone #5	Upon delivery of automation for Delphix Masking/Virtualization onboarding process	$60,000.00
	Total	$410,000.00

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements.**

1.1. Compliance with Medi-Cal Standards. Contractor agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract, including 42 C.F.R. § 438.230; Health & Safety Code § 1340 *et seq*. (unless otherwise excluded under the DHCS Contract); 28 C.F.R. § 1300.43 *et seq*.; Welfare & Institutions Code § 14000 *et seq*.; and 22 C.C.R. §§ 53800 *et seq*., 22 C.C.R. §§ 53900 *et seq*. Contractor and Subcontractors shall comply with all applicable requirements of the Medi-Cal program pertaining to its reporting requirements and other obligations under this Contract, including Medicaid and Medi-Cal laws and regulations, sub-regulatory guidance, DHCS all plan letters, and the DHCS Contract and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS. CalOptima or DHCS may revoke any activity under this Contract, including terminating this Contract, if Contractor and/or its Subcontractors do not perform that activity in compliance with the requirements in this Exhibit C. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.7-B.8, B.11, B.28; 42 C.F.R. § 438.230]

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit A, Attachment III, § 1.3.5 of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, Contractor shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the Contractor;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by Contractor; and

1.2.3. All creditors of Contractor's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. Contractor acknowledges and agrees that:

1.3.1. Contractor and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Contractor and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Contractor and its subcontractors agree to post in conspicuous places, available to

employees and applicants for employment, notices provided by the federal government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Contractor and its subcontractors' obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(f), Provision 1.a.]

1.3.2. Contractor and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Contractor and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(f), Provision 1.b.]

1.3.3. Contractor and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of Contractor and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(f), Provision 1.c.]

1.3.4. Contractor and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(f), Provision 1.d.]

1.3.5. Contractor and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(f), Provision 1.e.]

1.3.6. If Contractor and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Contractor and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(f), Provision 1.f.]

1.3.7. Contractor and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375,

"Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. Contractor and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Contractor and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, Contractor and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(f), Provision 1.g.]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the Contractor agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(f), Provision 20.a.]

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

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(f), Provision 20.b.(1)]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(f), Provision 20.b.(2)]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(f), Provision 20.b.(3)]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(f), Provisions 20.b.(4)(5)]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(f), Provision 20.b.(6)]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(f), Provision 20.b.(7)]

1.4.3. If the Contractor is unable to certify any of the statements in this certification, the Contractor shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(f), Provision 20.c.]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(f), Provision 20.d.]

1.4.5. If the Contractor knowingly violates this certification, in addition to other remedies available to the federal government, Contractor shall promptly notify CalOptima in writing, and CalOptima may terminate this Contract for cause. [DHCS Contract, Exhibit D(f), Provision 20.e.]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements.*

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, Contractor and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that Contractor and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(f), Provision 37.a.(1); 31 U.S.C. § 1352]

1.5.1.2. Contractor and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if Contractor and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(f), Provision 37.a.(2)]

1.5.1.3. Contractor and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Contractor and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(f), Provision 37.a.(3)]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(a)]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(b)]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(c)]

1.5.1.3.4. As applicable and required by this Section 1.5, Contractor's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(f), Provision 37.a.(4)]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by Contractor. Contractor shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(f), Provision 37.a.(5)]

1.5.2. *Prohibition.* 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress,

an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(f), Provision 37.b.]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, Contractor will timely gather, preserve, and provide, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of Contractor that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. Contractor and Subcontractors must maintain all books and records in accordance with good business practices and generally accepted accounting principles. This provision shall also apply to any agreement with a Contractor Subcontractor or an organization related to a Contractor Subcontractor by control or common ownership. Contractor further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records and any additional relevant information that regulating entities may require. Contractor further agrees and acknowledges that this provision will be included in any and all agreements with Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.12-B.15]

1.7. Confidentiality of Member Information.

1.7.1. If Contractor and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, Contractor and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Contractor, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and Contractor's obligations under this Contract. Contractor and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by Contractor from unauthorized disclosure. Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by Contractor or its

subcontractors, Contractor will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Contractor by CalOptima for this purpose. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.8. Member Hold Harmless. To the extent Contractor provides services or supplies to CalOptima members, Contractor hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. Contractor further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Contractor and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections A.13 and B.18; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Member Grievances. Contractor shall cooperate with CalOptima's member grievances and appeals procedures as necessary for CalOptima to carry out its legal obligations. [DHCS Contract, Exhibit A, Attachment III § 4.6; 28 C.C.R. §§ 1300.68, 1300.68.01; 22 C.C.R. § 53858; 43 C.F.R. § 438.402-424]

1.10. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), Contractor agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq.*), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq.*), as amended. [DHCS Contract, Exhibit D(f), Provision 12]

1.11. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5, subsection B.4]

1.12. Prospective Requirements. CalOptima will inform Contractor of prospective requirements added by the State, federal law, or DHCS to the DHCS Contract that would impact Contractor's obligations before the requirement becomes effective. Contractor agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. Contractor will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.22 and B.23]

1.13. DHCS Beneficiary. Contractor expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor agreement with respect to the obligations and functions undertaken under the Contract, and (ii) DHCS may directly enforce any and all provisions of the Contract or Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.29]

1.14. Termination. Contractor shall notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.17; APL 19-001, Attachment A, Requirement 13]

1.15. Cultural Competency. Contractor and Subcontractors must ensure that cultural competency, sensitivity, health equity, and diversity training is provided for Contractor's and Subcontractor's staff at key points of contact with CalOptima members, if applicable. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.24]

1.16. Interpreter Services. Contractor and Subcontractors, to the extent they communicate with CalOptima members, will provide interpreter services for members and comply with language assistance standards developed pursuant to Health and Safety Code § 1367.04 [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.25]

1.17. Fraud Reporting. Contractor and Subcontractors must notify CalOptima within ten (10) business days of any suspected fraud, waste, or abuse, and CalOptima may share such information with DHCS in accordance with Exhibit A, Attachment III, Section 1.3.2 (D), Fraud and Abuse Reporting, of the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.26]

1.18. Overpayment Reporting. Contractor and all Subcontractors must report directly to CalOptima, or through Contractor or Subcontractor, as applicable, when it has received an overpayment; return the overpayment to CalOptima within sixty (60) calendar days after the date the overpayment was identified; and notify CalOptima in writing of the reason for the overpayment. [42 C.F.R. § 438.608(d)(2); DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.27]

2. **Medicare Requirements.**

2.1. Contractor expressly warrants that Contractor and Contractor's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. Contractor further agrees and acknowledges that this provision will be included in all agreements with Contractor's subcontractors.

2.2. For any medical records or other health and enrollment information Contractor maintains with respect to Medicare enrollees, Contractor shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. Contractor shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within Contractor's organization; and (b) to whom and for what purposes Contractor will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. Contractor shall cooperate with CalOptima as necessary for CalOptima to comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, including Sections 422.516 and 422.310.

2.4. Contractor shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.5. For all contracts in the amount of $100,000 or more, Contractor and Contractor's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.5.1. Contractor and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.5.2. Contractor and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.6. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS, DHCS, or CalOptima determines that Contractor has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay Contractor its allowable

costs incurred to the date of termination. Thereafter, Contractor shall have no further claims against CalOptima for matters pertaining to this Contract.

2.7. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, Contractor shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.8. Contractor shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. Contractor shall promptly disclose to CalOptima any exclusion or other event that makes a Contractor employee or subcontractor ineligible to perform work related to federal health care programs. Contractor agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance.**

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. Contractor shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. Contractor represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. Contractor is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest.**

4.1. Contractor shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq.*) and California Government Code § 1090 *et seq.* (collectively, the "**Conflict of Interest Laws**").

4.2. Contractor covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. [22 C.C.R. § 53600(d)]. Contractor further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or contractor position by Contractor within one (1) year after the state office or state employee has terminated state employment.

4.3. Contractor, and any person designated by Contractor to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

4.4. Contractor understands that if this Contract is made in violation of California Government Code § 1090 *et seq.*, the entire Contract is voidable, Contractor will not be entitled to any compensation for services performed pursuant to this Contract, and Contractor will be required to reimburse CalOptima any sums paid to Contractor. Contractor further understands that Contractor may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.5. If Contractor becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, Contractor shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, Contractor agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of Contractor relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Axis Technology, LLC

Business Entity Type: LLC
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 50 Milk Street, 16th Floor

City: Boston State: MA Zip: 02109
Business Phone: 857-445-0110 Email: : legal@axistechnologyllc.com
President: Michael Logan Contact Person: Michael Logan

Person(s) Signing Contract & Title: : Michael Logan

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Michael Logan	CEO

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Signed by:
Michael J. Logan
2D47C7674B764E0...

Authorized Signature

2/20/2025
Date

Mike Logan CEO
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

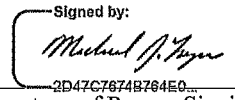
The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Axis Technology, LLC	Michael Logan
Name of Contractor	Printed Name of Person Signing for Contractor
Contract No. 25-010890	Signed by:  2D47C7674B764E0...
Contract/Grant Number	Signature of Person Signing for Contractor
2/20/2025	CEO
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier____, *if known*: Congressional District, *if known*:	Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
(attach Continuation Sheet(s) SF-LLLA, if necessary)	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, Including Officer(s), Employee(s), or Member(s) Contracted for Payment Indicated in Item 11:

(Attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

EXHIBIT F

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EXHIBIT G

CalOptima
Better. Together.

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal
Please check one of the following: ☒ Our Organization does not offshore any protected health information. **Please skip to Part V below** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below**	

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

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CalOptima
A Public Agency
Better. Together.

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Mike Logan	Title: CEO
Email: mikel@axistechnologyllc.com	Phone #: 857-445-0110
Signature: Signed by: 2D47C7674B764E0...	Date: 2/20/2025

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

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EXHIBIT H
Business Associate Contract

This Business Associate Agreement by and between CalOptima and Contractor, which for the purposes of this Agreement shall be referred to as "**Business Associate**", is effective as of the Effective Date of the Agreement or Memorandum of Understanding attached hereto.

RECITALS

WHEREAS, the Parties have executed an agreement(s) whereby Business Associate provides services to CalOptima, and Business Associate creates, receives, maintains, uses, transmits protected health information ("**PHI**") in order to provide those services ("**Services Agreement(s)**");

WHEREAS, as a covered entity, CalOptima is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("**HIPAA**") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations ("**C.F.R.**") Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("**Privacy Regulations**") and the Security Standards for Electronic Protected Health Information ("**Security Regulations**") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Business Associate is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

WHEREAS, CalOptima's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators' PHI and have required that CalOptima incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators' PHI;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the Parties agree as follows:

1. **Definitions**. The terms in this section and otherwise defined in this Business Associate Agreement shall have the definitions set forth below for purposes of this Business Associate Agreement. Terms used, but not otherwise defined, in this Business Associate Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, the IPA (as defined below), and/or regulations promulgated thereunder.

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1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, Use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential Information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data Aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated Record Set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **Disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic Health Record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic Media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** (**"ePHI"**) means Individually Identifiable Health Information, including PHI, that is transmitted by or maintained in Electronic Media.

1.11. **Health Care Operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually Identifiable Health Information** means health information, including demographic information collected from an Individual, that is created or received by a health

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care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, that identifies the Individual or where there is a reasonable basis to believe the information can be used to identify the Individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information System** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** ("**PHI**"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information ("**PI**") as defined in the Information Practices Act at California Civil Code § 1798.3(a) ("**IPA**"). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Reproductive Health Care** means health care, as defined at 45 CFR § 160.103, that affects the health of an Individual in all matters relating to the reproductive system and to its functions and processes.

1.17. **Required by Law** means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.18. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.19. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

1.20. **Services** has the same meaning as in the Services Agreement(s).

1.21. **Unsecured Protected Health Information** ("**Unsecured PHI**") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.22. **Use** and **Uses** mean, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

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2. CalOptima intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute PHI and/or Confidential Information protected by federal and/or state laws.

3. Business Associate is the business associate of CalOptima acting on CalOptima's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of CalOptima, and may create, receive, maintain, transmit, aggregate, Use or Disclose PHI in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may Use or Disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of CalOptima, provided that such Use or Disclosure would not violate HIPAA, including the Privacy Regulations, or other applicable laws if done by CalOptima.

   4.1. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may Use and Disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may Disclose PHI for this purpose if the Disclosure is Required by Law, or the Business Associate obtains reasonable assurances, in writing, from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

   4.2. **Data Aggregation**. If authorized as part of the Services provided to CalOptima under the Services Agreement, Business Associate may Use PHI to provide Data Aggregation services relating to the Health Care Operations of CalOptima.

5. **Prohibited Uses and Disclosures of PHI**

   5.1. **Restrictions on Certain Disclosures to Health Plans**. Business Associate shall not Disclose PHI about an Individual to a health plan for payment or Health Care Operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

   5.2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima and CalOptima's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

   5.3. **Prohibition of Disclosure of PHI Related to Reproductive Health Care**. Business Associate shall comply with 45 C.F.R. Part 164, Subpart E regarding uses and disclosures of Reproductive Health Care-related information, including the following:

5.3.1. Business Associate shall comply with requirements of 45 § C.F.R. 164.502(a)(5)(iii) and shall not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described (each a "**Prohibited Purpose**").

5.3.2. To the extent applicable, if Business Associate receives a request for Reproductive Health Care-related information for a non-Prohibited Purpose that is otherwise permissible under HIPAA, HITECH, the Privacy Regulations, and the Security Regulations, Business Associate shall obtain a valid attestation under 45 C.F.R. § 164.509 if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under 45 C.F.R. § 164.512(d); (ii) judicial or administrative proceedings under 45 C.F.R. § 164.512(e); (iii) disclosures for law enforcement purposes under 45 C.F.R. § 164.512(f); or (iv) disclosures about decedents to coroners and medical examiners under 45 C.F.R. § 164.512(g)(1).

6. **Compliance with Other Applicable Laws**

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

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

6.1.2. To treat any violation of such additional and/or more protective standards as a Breach or Security Incident, as appropriate, pursuant to Section 17 of this Agreement.

6.2. Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or Confidential Information, as defined in Section 1.4 of this Agreement, include, but are not limited to the IPA, California Civil Code §§ 1798-1798.78, California Confidentiality of Medical Information Act ("**CMIA**"), Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5. Business Associate shall ensure that any Medical Information related to Sensitive Services (as those terms are defined under Civil Code § 56.05) received or accessed under the Agreement is kept confidential, segregated, and only disclosed, accessed, transferred, transmitted, or processed in accordance with CMIA requirements, including Civil Code §§ 56.10, 56.11, 56.107, 56.108, and 56.110, as applicable.

6.3. If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions

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(2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

7.1. **Nondisclosure.** Business Associate shall not Use or Disclose PHI or other Confidential Information other than as permitted or required by this Agreement or as Required by Law.

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent Use or Disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

7.2.2. Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls, and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time.

7.2.3. Business Associate shall employ FIPS 140-3 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other Confidential Information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

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

7.2.5. Business Associate shall ensure that all members of its workforce with access to PHI and/or other Confidential Information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

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

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7.3. **Minimum Necessary**. With respect to any permitted Use, Disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **Business Associate's Agent**. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "**Agents**") that Use or Disclose PHI and/or Confidential Information on behalf of Business Associate agree through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or Confidential Information.

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

9. **Access to PHI**. Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima. If Business Associate maintains an Electronic Health Record with PHI and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524.

9.1. **Business Associate of CalOptima PACE**. This Section applies when Business Associate is a business associate of CalOptima in CalOptima's capacity as a health care provider through CalOptima Program of All-Inclusive Care for the Elderly ("**CalOptima PACE**"). Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set or patient records (as defined in California Health and Safety Code § 123105), make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. To enable compliance with California Health & Safety Code § 123110 and 45 C.F.R. § 164.524, Business Associate shall provide such access for inspection of that PHI within three (3) working days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima.

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526, as requested by CalOptima in the time and manner designated by CalOptima.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima or (at the direction of CalOptima) to an Individual such disclosures of PHI and information related to such disclosures as necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations, including 45 C.F.R. § 164.528. Unless directed by CalOptima to make available to an Individual, Business Associate shall provide to CalOptima, within thirty (30) calendar days after receipt of request from CalOptima, information collected in accordance

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with this Section 11 to permit CalOptima to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

11.1. The date of the disclosure;

11.2. The name, and address if known, of the entity or person who received the PHI;

11.3. A brief description of the PHI disclosed; and

11.4. A brief statement of the purpose of the disclosure.

For each Disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima or DHCS**. To the extent Business Associate is to carry out an obligation of CalOptima or the California Department of Healthcare Services ("**DHCS**") under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart E that apply to CalOptima or DHCS, as applicable, in the performance of such obligation.

14. **Access to Practices, Books and Records**. Business Associate shall make its internal practices, books, and records relating to the Use and disclosure of PHI on behalf of CalOptima available to CalOptima upon reasonable request, and to the DHCS and the Secretary for purposes of determining CalOptima's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI on behalf of CalOptima available to DHCS, CalOptima, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, CMIA, and implementing regulations. Business Associate shall immediately notify CalOptima of any requests made by DHCS or the Secretary and provide CalOptima with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima or, if agreed to by CalOptima, destroy all PHI and other Confidential Information received from, or created or received by Business Associate on behalf of, CalOptima that Business Associate or its Agents still maintains in any form, and shall retain no copies of such information. If CalOptima elects destruction of PHI and/or other Confidential Information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15.1 and 15.2 below and shall certify in writing to CalOptima that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima of the conditions that make the return or destruction infeasible. Subject to the approval of CalOptima's regulator(s) if necessary, if such return or destruction is not feasible, CalOptima shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

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15.1 **Data Destruction.** Data destruction methods for CalOptima PHI or Confidential Information must conform to the NIST Special Publication 800-88. Other methods require prior written permission of CalOptima and, if necessary, CalOptima's regulator(s).

15.2 **Destruction of Hard Copy Confidential Data.** CalOptima PHI or Confidential Information in hard copy form must be disposed of through confidential means, such as cross cut shredding and pulverizing.

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

17. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any Breach or Security Incident, and take the following steps:

17.1. **Notice to CalOptima**

17.1.1. **Immediate Notice.** Business Associate shall notify CalOptima immediately upon the discovery of a suspected Breach or Security Incident that involves SSA Data. This notification will be provided by email upon discovery of the Breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to CalOptima.

17.1.2. **24-Hour Notice.** Business Associate shall notify CalOptima within 24 hours by email (or by telephone if Business Associate is unable to email CalOptima) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

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

17.1.2.2. Any suspected Security Incident which risks unauthorized access to PHI and/or other Confidential Information;

17.1.2.3. Any intrusion or unauthorized access, Use or Disclosure of PHI in violation of this Agreement; or

17.1.2.4. Potential loss of confidential data affecting this Agreement.

17.1.3. Notice shall be provided to the CalOptima Privacy Officer ("**CalOptima Contact**") using the CalOptima Contact Information at Section 17.7 below. Such notification by Business Associate shall comply with CalOptima's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

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17.2. **Required Actions**. Upon discovery of a Breach or suspected Security Incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

17.2.1. Prompt action to mitigate any risks or damages involved with the Security Incident or Breach;

17.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

17.2.3. Any corrective actions required by CalOptima or CalOptima's regulator(s).

17.3. **Investigation**. Business Associate shall immediately investigate such Security Incident or confidential Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting such privacy incident.

17.3.1. Incident details including the date of the incident and when it was discovered;

17.3.2. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;

17.3.3. The nature of the data elements involved and the extent of the data involved in the Breach;

17.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

17.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

17.3.6. A description of the probable causes of the improper Use or Disclosure;

17.3.7. Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);

17.3.8. Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured PHI;

17.3.9. Whether a law enforcement official has requested a delay in notification of Individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or Confidential Information because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

17.3.10. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

17.4. **Complete Report**. Business Associate shall provide a complete written report of the

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investigation ("Final Report") to the CalOptima Contact within seven (7) working days of the discovery of the Security Incident or Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting of such privacy incident.

17.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17.3 above and the following:

17.4.1.1. An assessment of all known factors relevant to a determination of whether a Breach occurred under HIPAA and other applicable federal and state laws;

17.4.1.2. A full, detailed corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future, including its implementation date and information on mitigation measures taken to halt and/or contain the improper Use or Disclosure and to reduce the harmful effects of the Breach. All corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s), as applicable; and

17.4.1.3. The potential impacts of the incident, such as potential misuse of data and identity theft.

17.4.2. If CalOptima or CalOptima's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

17.4.3. CalOptima and CalOptima's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a Breach occurred, whether the Security Incident or Breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

17.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17.4 above, Business Associate shall request approval from CalOptima within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima and, if necessary, CalOptima's regulator(s).

17.5. **Notification of Individuals.** If the cause of a Breach is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify Individuals accordingly and pay all costs of such notifications, as well as costs associated with the Breach. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with CalOptima. CalOptima and CalOptima regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima and CalOptima regulator(s), as applicable, must be obtained before the

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notifications are made.

17.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima**. If the cause of a Breach of PHI is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate agrees that CalOptima shall make all required reporting of the Breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

17.7. **CalOptima Contact Information**. To direct communications to CalOptima Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

CalOptima Privacy Office

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

18. **Responsibilities of CalOptima**

18.1 CalOptima agrees to not request the Business Associate to Use or Disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

18.2 **Notification of SSA Data**. CalOptima shall notify Business Associate if Business Associate receives data that is SSA Data from or on behalf of CalOptima.

19. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima for and hold it harmless from (i) any and all fees and expenses CalOptima incurs in investigating, responding to, and/or mitigating a Breach of PHI or Confidential Information caused by Business Associate or its Agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima due to a claim, lawsuit, or demand by a third party arising out of a Breach of PHI or Confidential Information caused by Business Associate or its Agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima by any government agency/regulator based on a Breach of PHI or Confidential Information caused by Business Associate or its Agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of Breach to Individuals and regulators, and required reporting of Breach. Acceptance by CalOptima of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

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20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima and/or CalOptima's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the CalOptima Privacy Officer in writing. Whether or how CalOptima or CalOptima's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

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

21. **Term and Termination**

21.1 **Term.** This exhibit is effective as of the Effective Date and shall terminate when (i) the Services Agreement terminates, (ii) in accordance with this Section 21, or (iii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 15.

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

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

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

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

22. **Miscellaneous Provisions**

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

22.2. **Amendment**

22.2.1. Any provision of this Agreement which is in conflict with current or future applicable federal or state laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be

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effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2. In addition to automatic amendments under Section 22.2.1, CalOptima reserves the right to amend the Agreement at any time when such modifications are necessary to comply with changes in (i) applicable laws, (ii) CalOptima's contracts with government regulators, or (iii) in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall promptly notify Business Associate in writing of such Regulatory Changes in accordance with applicable federal and/or State requirements, and Business Associate shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a CalOptima government regulator.

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

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

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

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

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

22.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

22.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or Confidential Information by Business Associate or any agent, subcontractor, employee or third party that received PHI or Confidential Information, and Business Associate agrees that CalOptima may seek injunctive relief under this section without any requirement to prove actual monetary damage or post a bond or other security.

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22.9 **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of CalOptima's contracts with regulator(s) or any other monitoring requests by CalOptima's regulator(s).

EXECUTION

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima, this Business Associate Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate	CalOptima
George L. Barroso	Michael Hunn
Print Name	Print Name
DocuSigned by: George L. Barroso	Signed by: Michael Hunn EDDDDCC19C894FB...
Signature	Signature
Vice President, Data Solutions	CEO
Title	Title
2/20/2025	02/25/2025
Date	Date
Mike Logan	Nancy Huang
Print Name	Print Name
Signed by: 2D47D7B74B1E4E0...	Signed by: Nancy Huang D22E3B87032946F...
Signature	Signature
CEO	CFO, CalOptima
Title	Title
2/20/2025	02/24/2025
Date	Date

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Axis Technology, LLC	50 Milk Street, 16th Floor	Boston	MA	02109

Financial Summary

January 31, 2025

Board of Directors Meeting
March 6, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Financial Highlights: January 2025

January 2025 Actual	January 2025 Budget	January 2025 $ Variance	January 2025 % Variance		July 2024 - January 2025 Actual	July 2024 - January 2025 Budget	July 2024 - January 2025 $ Variance	July 2024 - January 2025 % Variance
915,151	900,180	14,971	1.7%	Member Months	6,392,580	6,303,938	88,642	1.4%
398,727,072	359,411,884	39,315,188	10.9%	Revenues	2,822,267,503	2,492,845,725	329,421,778	13.2%
354,104,305	355,767,909	1,663,604	0.5%	Medical Expenses	2,629,007,660	2,502,393,793	(126,613,867)	(5.1%)
23,715,309	26,138,683	2,423,374	9.3%	Administrative Expenses	145,245,575	171,309,235	26,063,660	15.2%
20,907,458	**(22,494,708)**	**43,402,166**	**192.9%**	**Operating Margin**	**48,014,267**	**(180,857,303)**	**228,871,570**	**126.5%**
				Non-Operating Income (Loss)				
15,418,624	6,666,660	8,751,964	131.3%	Net Investment Income/Expense	115,944,186	46,666,620	69,277,566	148.5%
(24,044)	(117,280)	93,236	79.5%	Net Rental Income/Expense	(355,949)	(820,960)	465,011	56.6%
(3,398)	-	(3,398)	(100.0%)	Net MCO Tax	(1,699)	-	(1,699)	(100.0%)
(815,467)	(1,178,825)	363,358	30.8%	Grant Expense	(13,356,363)	(8,160,866)	(5,195,497)	(63.7%)
1,404	-	1,404	100.0%	Other Income/Expense	70,850	-	70,850	100.0%
14,577,120	**5,370,555**	**9,206,565**	**171.4%**	**Total Non-Operating Income (Loss)**	**102,301,025**	**37,684,794**	**64,616,231**	**171.5%**
35,484,578	**(17,124,153)**	**52,608,731**	**307.2%**	**Change in Net Assets**	**150,315,292**	**(143,172,509)**	**293,487,801**	**205.0%**
88.8%	*99.0%*	*(10.2%)*		*Medical Loss Ratio*	*93.2%*	*100.4%*	*(7.2%)*	
5.9%	*7.3%*	*1.3%*		*Administrative Loss Ratio*	*5.1%*	*6.9%*	*1.7%*	
5.2%	*(6.3%)*	*11.5%*		*Operating Margin Ratio*	*1.7%*	*(7.3%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
83.0%	*94.1%*	*(11.1%)*		**Adjusted MLR*	*87.4%*	*95.5%*	*(8.1%)*	
5.9%	*7.3%*	*1.3%*		**Adjusted ALR*	*5.4%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

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Financial Highlights Notes: January 2025

- Notable events/items in January 2025
  - Revenue was estimated by utilizing the updated Calendar Year (CY) 2025 draft premium capitation rates from the Department of Health Care Services (DHCS)
    - CY 2025 draft rates came in favorable compared to our original budget. Staff anticipates additional rate amendments from DHCS due to program and member acuity changes
  - $5.4 million in Student Behavioral Health Incentive Program (SBHIP) revenue recognized and paid during the month

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FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) January 2025: $35.5 million, favorable to budget $52.6 million or 307.2% primarily due to:
    - Favorable net investment income, enrollment and CY 2025 premium capitation rates
  - Year To Date (YTD) July 2024 – January 2025: $150.3 million, favorable to budget $293.5 million or 205.0% primarily due to:
    - Favorable net investment income, premium capitation rates and enrollment in the Medi-Cal (MC) Line of Business (LOB)

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FY 2024-25: Management Summary (cont.)

- Enrollment
  - MTD: 915,151 members, favorable to budget 14,971 or 1.7%
  - YTD: 6,392,580 member months, favorable to budget 88,642 or 1.4%

- Revenue
  - MTD: $398.7 million, favorable to budget $39.3 million or 10.9% primarily due to favorable enrollment, CY 2025 premium capitation rates and SBHIP
  - YTD: $2,822.3 million, favorable to budget $329.4 million or 13.2% driven by MC LOB due to CY 2022 Hospital Directed Payments (DP), favorable enrollment and premium capitation rates

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FY 2024-25: Management Summary (cont.)

- Medical Expenses
  - MTD: $354.1 million, favorable to budget $1.7 million or 0.5% driven by:
    - $15.1 million in MC Facilities, Professional, and Managed Long-Term Services and Supports (MLTSS) Claims due to lower than expected utilization
    - Offset by:
      - $5.4 million in MC Other Medical Expenses primarily due to CY 2025 Community Reinvestment and Quality Achievement accruals
      - $4.9 million in MC Provider Capitation due to AltaMed's transition to HMO
      - $4.2 million in MC Incentive Payments expenses due to SBHIP payments

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FY 2024-25: Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $2,629.0 million, unfavorable to budget $126.6 million or 5.1% driven by:
    - $164.8 million in MC Other Medical Expenses due primarily to CY 2022 Hospital DP and CY 2025 Community Reinvestment and Quality Achievement accruals
    - Offset by $16.4 million in MC Incentive Payments expenses due to the timing of Hospital Quality Program (HQP) accruals

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FY 2024-25: Management Summary (cont.)

- Administrative Expenses
  - MTD: $23.7 million, favorable to budget $2.4 million or 9.3%
  - YTD: $145.2 million, favorable to budget $26.1 million or 15.2%

- Non-Operating Income (Loss)
  - MTD: $14.6 million, favorable to budget $9.2 million or 171.4% primarily due to net investment income of $8.8 million
  - YTD: $102.3 million, favorable to budget $64.6 million or 171.5% primarily due to favorable net investment income of $69.3 million, offset by unfavorable grant expense of $5.2 million

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FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	88.8%	99.0%	(10.2%)
	Adjusted MLR*	83.0%	94.1%	(11.1%)
YTD	MLR	93.2%	100.4%	(7.2%)
	Adjusted MLR*	87.4%	95.5%	(8.1%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.9%	7.3%	1.3%
	Adjusted ALR*	5.9%	7.3%	1.3%
YTD	ALR	5.1%	6.9%	1.7%
	Adjusted ALR*	5.4%	6.9%	1.5%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Directed Payments and Community Reinvestment Accruals, but include costs associated with DTS.

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FY 2024-25: Key Financial Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.9
  - Board Designated Reserve level: 2.92
  - Statutory Designated Reserve level: 1.05
  - Net-position: $2.6 billion, including required Tangible Net Equity (TNE) of $129.3 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: January 2025

January 2025					July 2024 - January 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
147,236	137,885	9,351	6.8%	SPD	1,020,028	958,218	61,810	6.5%
265,619	271,904	(6,285)	(2.3%)	TANF Child	1,880,294	1,906,512	(26,218)	(1.4%)
131,708	138,169	(6,461)	(4.7%)	TANF Adult	918,001	965,465	(47,464)	(4.9%)
2,507	2,600	(93)	(3.6%)	LTC	17,429	18,245	(816)	(4.5%)
340,646	322,277	18,369	5.7%	MCE	2,364,937	2,263,266	101,671	4.5%
9,843	9,543	300	3.1%	WCM	68,010	66,913	1,097	1.6%
897,559	**882,378**	**15,181**	**1.7%**	**Medi-Cal Total**	**6,268,699**	**6,178,619**	**90,080**	**1.5%**
17,090	**17,319**	**(229)**	**(1.3%)**	**OneCare**	**120,356**	**121,992**	**(1,636)**	**(1.3%)**
502	**483**	**19**	**3.9%**	**PACE**	**3,525**	**3,327**	**198**	**6.0%**
533	**568**	**(35)**	**(6.2%)**	**MSSP**	**3,522**	**3,976**	**(454)**	**(11.4%)**
0	**0**	**0**	**0.0%**	**Covered CA**	**0**	**0**	**0**	**0.0%**
915,151	**900,180**	**14,971**	**1.7%**	**CalOptima Health Total**	**6,392,580**	**6,303,938**	**88,642**	**1.4%**

Note: MSSP enrollment is included in Medi-Cal Total.

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Consolidated Revenue & Expenses: January 2025 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	897,559	17,090		502	533		915,151
REVENUES							
Capitation Revenue	$ 357,619,458	$ 36,232,949	$ -	$ 4,623,607	$ 251,059	$ -	$ 398,727,072
Total Operating Revenue	**357,619,458**	**36,232,949**	**-**	**4,623,607**	**251,059**	**-**	**398,727,072**
MEDICAL EXPENSES							
Provider Capitation	116,284,008	15,584,301					131,868,310
Claims	128,145,167	6,828,260	(184,151)	1,760,384			136,549,659
MLTSS	41,390,297			4,846	39,371		41,434,514
Prescription Drugs		9,394,377		564,814			9,959,191
Case Mgmt & Other Medical	30,572,074	2,093,597		1,418,137	208,823		34,292,631
Total Medical Expenses	**316,391,546**	**33,900,535**	**(184,151)**	**3,748,181**	**248,194**	**-**	**354,104,305**
Medical Loss Ratio	*88.5%*	*93.6%*	*0.0%*	*81.1%*	*98.9%*	*0.0%*	*88.8%*
GROSS MARGIN	**41,227,912**	**2,332,414**	**184,151**	**875,426**	**2,864**	**-**	**44,622,767**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	13,437,746	1,296,770		199,373	122,880		15,056,769
Non-Salary Operating Expenses	3,113,343	776,696		40,292	1,417		3,931,747
Depreciation & Amortization	735,753			1,003			736,756
Other Operating Expenses	3,374,444	219,421		11,672	8,001		3,613,538
Indirect Cost Allocation, Occupancy	(666,034)	1,019,094		16,799	6,639		376,498
Total Administrative Expenses	**19,995,253**	**3,311,981**	**-**	**269,138**	**138,937**	**-**	**23,715,309**
Administrative Loss Ratio	*5.6%*	*9.1%*	*0.0%*	*5.8%*	*55.3%*	*0.0%*	*5.9%*
Operating Income/(Loss)	**21,232,659**	**(979,568)**	**184,151**	**606,288**	**(136,073)**	**-**	**20,907,458**
Investments and Other Non-Operating	(1,994)						14,577,120
CHANGE IN NET ASSETS	**$ 21,230,665**	**$ (979,568)**	**$ 184,151**	**$ 606,288**	**$ (136,073)**	**$ -**	**$ 35,484,578**
BUDGETED CHANGE IN NET ASSETS	(20,192,416)	(1,129,303)	-	(138,399)	(117,924)	(916,666)	(17,124,153)
Variance to Budget - Fav/(Unfav)	$ 41,423,081	$ 149,735	$ 184,151	$ 744,687	$ (18,149)	$ 916,666	$ 52,608,731

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CalOptima Health

Consolidated Revenue & Expenses: January 2025 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	6,268,699	120,356		3,525	3,522		6,392,580
REVENUES							
Capitation Revenue	$ 2,554,971,986	$ 238,295,364	$ (3,197,365)	$ 30,585,384	$1,612,134	$ -	$ 2,822,267,503
Total Operating Revenue	**2,554,971,986**	**238,295,364**	**(3,197,365)**	**30,585,384**	**1,612,134**	**-**	**2,822,267,503**
MEDICAL EXPENSES							
Provider Capitation	797,430,624	101,974,263	(1,453,037)				897,951,850
Claims	923,882,801	42,906,351	(184,151)	11,187,791			977,792,792
MLTSS	344,027,689			83,147	260,873		344,371,710
Prescription Drugs		61,609,857		4,117,895			65,727,752
Case Mgmt & Other Medical	322,072,911	10,867,139		8,908,401	1,315,106		343,163,556
Total Medical Expenses	**2,387,414,025**	**217,357,610**	**(1,637,188)**	**24,297,234**	**1,575,979**	**-**	**2,629,007,660**
Medical Loss Ratio	*93.4%*	*91.2%*	*51.2%*	*79.4%*	*97.8%*	*0.0%*	*93.2%*
GROSS MARGIN	**167,557,961**	**20,937,754**	**(1,560,177)**	**6,288,149**	**36,155**	**-**	**193,259,842**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	79,969,756	7,659,276		1,183,775	711,732		89,524,539
Non-Salary Operating Expenses	24,718,086	3,600,259		404,382	9,940		28,732,668
Depreciation & Amortization	5,180,647			6,748			5,187,395
Other Operating Expenses	18,793,863	377,457		65,054	54,145		19,290,518
Indirect Cost Allocation, Occupancy	(5,505,592)	7,838,818		124,654	52,576		2,510,456
Total Administrative Expenses	**123,156,760**	**19,475,809**	**-**	**1,784,612**	**828,394**	**-**	**145,245,575**
Administrative Loss Ratio	*4.8%*	*8.2%*	*0.0%*	*5.8%*	*51.4%*	*0.0%*	*5.1%*
Operating Income/(Loss)	**44,401,201**	**1,461,944**	**(1,560,177)**	**4,503,537**	**(792,239)**	**-**	**48,014,267**
Investments and Other Non-Operating	69,151						102,301,025
CHANGE IN NET ASSETS	**$ 44,470,352**	**$ 1,461,944**	**$ (1,560,177)**	**$ 4,503,537**	**$ (792,239)**	**$ -**	**$ 150,315,292**
BUDGETED CHANGE IN NET ASSETS	(169,662,466)	(8,606,907)	-	(875,151)	(796,113)	(916,666)	(143,172,509)
Variance to Budget - Fav/(Unfav)	$ 214,132,818	$ 10,068,851	$ (1,560,177)	$ 5,378,688	$ 3,874	$ 916,666	$ 293,487,801

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CalOptima Health

Balance Sheet: As of January 2025

ASSETS	
Current Assets	
Operating Cash	$470,286,895
Short-term Investments	1,717,421,060
Capitation Receivable	728,404,881
Receivables - Other	97,673,244
Prepaid Expenses	13,759,190
Total Current Assets	**3,027,545,271**
Capital Assets	
Capital Assets	192,809,346
Less Accumulated Depreciation	(91,301,191)
Capital Assets, Net of Depreciation	**101,508,156**
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,091,569,915
Statutory Designated Reserves	136,311,403
Total Other Assets	**1,228,181,318**
TOTAL ASSETS	**4,357,234,744**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,433,133,751**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$351,118,555
Medical Claims Liability	1,070,061,981
Accrued Payroll Liabilities	23,142,071
Deferred Revenue	44,342,333
Other Current Liabilities	-
Capitation and Withholds	128,169,083
Total Current Liabilities	**1,616,834,023**
Other Liabilities	
GASB 96 Subscription Liabilities	20,237,234
Community Reinvestment	128,162,741
Capital Lease Payable	266,593
Postemployment Health Care Plan	17,607,889
Net Pension Liabilities	45,981,359
Total Other Liabilities	**212,255,816**
TOTAL LIABILITIES	**1,829,089,839**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	129,294,670
Funds in Excess of TNE	2,466,102,797
TOTAL NET POSITION	**2,595,397,467**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,433,133,751**

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Board Designated Reserve and TNE Analysis: As of January 2025

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	545,821,093				
MetLife Tier One	545,748,822				
Board Designated Reserves	1,091,569,915	934,101,583	1,120,921,899	157,468,332	(29,351,985)
Current Reserve Level (X months of average monthly revenue) [1]	*2.92*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,263,488				
MetLife Tier Two	68,047,915				
Statutory Designated Reserves	136,311,403	129,294,670	142,224,137	7,016,733	(5,912,734)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

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

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Spending Plan: As of January 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 1/31/2025	**$2,595.4**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,091.6**			**42.1%**
	Statutory Designated Reserve[1]	**$136.3**			**5.3%**
	Capital Assets, net of Depreciation[2]	**$101.5**			**3.9%**
Resources Allocated[3]	Homeless Health Initiative[3]	$16.0	$61.7	$45.7	0.6%
	Housing and Homelessness Incentive Program[3]	22.1	87.4	65.3	0.9%
	Intergovernmental Transfers (IGT)	54.5	111.7	57.2	2.1%
	Digital Transformation and Workplace Modernization[4]	43.2	100.0	56.8	1.7%
	Mind OC Grant (Orange)	0.1	1.0	0.9	0.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.8%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.2	4.7	3.5	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	127.1	153.5	26.4	4.9%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.8	50.0	5.2	1.7%
	Distribution Event - Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	6.3	107.5	101.2	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	4.0	7.6	3.6	0.2%
	Quality Initiatives from unearned Pay for Value Program	19.2	23.3	4.1	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	403.4	526.2	122.8	15.5%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	Subtotal:	**$855.3**	**$1,422.6**	**$567.2**	**33.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$410.7**			**15.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 142 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

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Homeless Health Initiative and Allocated Funds: As of January 2025

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	871,058	92,203
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,883,740	6,005,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	7,327,227	2,749,425
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$45,740,977**	**$56,059,023**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$45,740,977**	**$15,959,023**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

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Housing and Homelessness Incentive Program
As of January 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	28,988,750	25,942,244	18,000,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,316,753	22,067,777	-
Total	**160,315,719**	**142,315,524**	**94,305,503**	**48,010,021**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	824,600	575,400	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,021,311	1,600,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	508,429	191,571	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$94,005,502**	**$39,180,023**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

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UNAUDITED FINANCIAL STATEMENTS

January 31, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the Seven Months Ending January 31, 2025

January 2025					July 2024 - January 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
915,151	900,180	14,971	1.7%	Member Months	6,392,580	6,303,938	88,642	1.4%
398,727,072	359,411,884	39,315,188	10.9%	Revenues	2,822,267,503	2,492,845,725	329,421,778	13.2%
354,104,305	355,767,909	1,663,604	0.5%	Medical Expenses	2,629,007,660	2,502,393,793	(126,613,867)	(5.1%)
23,715,309	26,138,683	2,423,374	9.3%	Administrative Expenses	145,245,575	171,309,235	26,063,660	15.2%
20,907,458	**(22,494,708)**	**43,402,166**	**192.9%**	**Operating Margin**	**48,014,267**	**(180,857,303)**	**228,871,570**	**126.5%**
				Non-Operating Income (Loss)				
15,418,624	6,666,660	8,751,964	131.3%	Net Investment Income/Expense	115,944,186	46,666,620	69,277,566	148.5%
(24,044)	(117,280)	93,236	79.5%	Net Rental Income/Expense	(355,949)	(820,960)	465,011	56.6%
(3,398)	-	(3,398)	(100.0%)	Net MCO Tax	(1,699)	-	(1,699)	(100.0%)
(815,467)	(1,178,825)	363,358	30.8%	Grant Expense	(13,356,363)	(8,160,866)	(5,195,497)	(63.7%)
1,404	-	1,404	100.0%	Other Income/Expense	70,850	-	70,850	100.0%
14,577,120	**5,370,555**	**9,206,565**	**171.4%**	**Total Non-Operating Income (Loss)**	**102,301,025**	**37,684,794**	**64,616,231**	**171.5%**
35,484,578	**(17,124,153)**	**52,608,731**	**307.2%**	**Change in Net Assets**	**150,315,292**	**(143,172,509)**	**293,487,801**	**205.0%**
88.8%	*99.0%*	*(10.2%)*		*Medical Loss Ratio*	*93.2%*	*100.4%*	*(7.2%)*	
5.9%	*7.3%*	*1.3%*		*Administrative Loss Ratio*	*5.1%*	*6.9%*	*1.7%*	
5.2%	*(6.3%)*	*11.5%*		*Operating Margin Ratio*	*1.7%*	*(7.3%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
83.0%	*94.1%*	*(11.1%)*		**Adjusted MLR*	*87.4%*	*95.5%*	*(8.1%)*	
5.9%	*7.3%*	*1.3%*		**Adjusted ALR*	*5.4%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

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CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Seven Months Ending January 31, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,320	1,361	41
OneCare	168	186	18
PACE	107	113	6
MSSP	22	25	3
Total	1,617	1,685	68

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	9,080	9,526	446
OneCare	1,196	1,302	106
PACE	742	791	49
MSSP	147	175	28
Total	11,164	11,794	630

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	680	648	(32)
OneCare	102	93	(9)
PACE	5	4	(1)
MSSP	25	23	(2)
Consolidated	566	534	(32)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	690	649	(41)
OneCare	101	94	(7)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	573	535	(38)

Open FTE			
	Total	Medical	Admin
Medi-Cal	65	35	30
OneCare	12	10	2
PACE	5	5	0
MSSP	1	1	0
Total	83	51	32

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending January 31, 2025

MEMBER MONTHS		915,151		900,180		14,971
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$357,619,458	$398.44	$318,736,677	$361.22	$38,882,781	$37.22
OneCare	36,232,949	2,120.13	36,352,332	2,098.99	(119,383)	21.14
OneCare Connect	-	-	-	0.00	-	0.00
PACE	4,623,607	9,210.37	4,069,358	8,425.17	554,249	785.20
MSSP	251,059	471.03	253,517	446.33	(2,458)	24.70
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	398,727,072	435.70	359,411,884	399.27	39,315,188	36.43
MEDICAL EXPENSES						
Medi-Cal	316,391,546	352.50	317,430,529	359.74	1,038,983	7.24
OneCare	33,900,535	1,983.65	34,193,856	1,974.36	293,321	(9.29)
OneCare Connect	(184,151)	0.00	-	0.00	184,151	0.00
PACE	3,748,181	7,466.50	3,902,783	8,080.30	154,603	613.80
MSSP	248,194	465.66	240,741	423.84	(7,453)	(41.82)
Covered CA	-	0.00	-	0.00	-	0.00
Total Medical Expenses	354,104,305	386.94	355,767,909	395.22	1,663,604	8.28
GROSS MARGIN	44,622,767	48.76	3,643,975	4.05	40,978,792	44.71
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	15,056,769	16.45	14,085,785	15.65	(970,984)	(0.80)
Professional Fees	1,594,741	1.74	2,703,494	3.00	1,108,753	1.26
Purchased Services	1,800,510	1.97	3,166,864	3.52	1,366,354	1.55
Printing & Postage	536,496	0.59	784,898	0.87	248,402	0.28
Depreciation & Amortization	736,756	0.81	1,027,958	1.14	291,202	0.33
Other Expenses	3,613,538	3.95	3,925,911	4.36	312,372	0.41
Indirect Cost Allocation, Occupancy	376,498	0.41	443,773	0.49	67,275	0.08
Total Administrative Expenses	23,715,309	25.91	26,138,683	29.04	2,423,374	3.13
NET INCOME (LOSS) FROM OPERATIONS	20,907,458	22.85	(22,494,708)	(24.99)	43,402,166	47.84
INVESTMENT INCOME						
Interest Income	14,214,425	15.53	6,666,660	7.41	7,547,765	8.12
Realized Gain/(Loss) on Investments	208,617	0.23	-	-	208,617	0.23
Unrealized Gain/(Loss) on Investments	995,582	1.09	-	-	995,582	1.09
Total Investment Income	15,418,624	16.85	6,666,660	7.41	8,751,964	9.44
NET RENTAL INCOME/EXPENSE	(24,044)	(0.03)	(117,280)	(0.13)	93,236	0.10
NET MCO TAX	(3,398)	-	-	-	(3,398)	-
GRANT EXPENSE	(815,467)	(0.89)	(1,178,825)	(1.31)	363,358	0.42
OTHER INCOME/EXPENSE	1,404	-	-	-	1,404	-
CHANGE IN NET ASSETS	**35,484,578**	**38.77**	**(17,124,153)**	**(19.02)**	**52,608,731**	**57.79**
MEDICAL LOSS RATIO	**88.8%**		**99.0%**		**(10.2%)**	
ADMINISTRATIVE LOSS RATIO	**5.9%**		**7.3%**		**1.3%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

MEMBER MONTHS		6,392,580		6,303,938		88,642
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$2,554,971,986	$407.58	$2,217,606,284	$358.92	$337,365,702	$48.66
OneCare	238,295,364	1,979.92	245,814,837	2,015.01	(7,519,473)	(35.09)
OneCare Connect	(3,197,365)	0.00	-		(3,197,365)	0.00
PACE	30,585,384	8,676.70	27,649,985	8,310.79	2,935,399	365.91
MSSP	1,612,134	457.73	1,774,619	446.33	(162,485)	11.40
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	2,822,267,503	441.49	2,492,845,725	395.44	329,421,778	46.05
MEDICAL EXPENSES						
Medi-Cal	2,387,414,025	380.85	2,242,314,437	362.92	(145,099,588)	(17.93)
OneCare	217,357,610	1,805.96	231,954,799	1,901.39	14,597,189	95.43
OneCare Connect	(1,637,188)	0.00	-	0.00	1,637,188	0.00
PACE	24,297,234	6,892.83	26,439,370	7,946.91	2,142,136	1,054.08
MSSP	1,575,979	447.47	1,685,187	423.84	109,208	(23.63)
Covered CA	-	0.00	-	0.00	-	0.00
Total Medical Expenses	2,629,007,660	411.26	2,502,393,793	396.96	(126,613,867)	(14.30)
GROSS MARGIN	193,259,842	30.23	(9,548,068)	(1.52)	202,807,910	31.75
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	89,524,539	14.00	95,076,705	15.08	5,552,166	1.08
Professional Fees	9,106,923	1.42	12,283,342	1.95	3,176,419	0.53
Purchased Services	16,119,780	2.52	20,781,398	3.30	4,661,618	0.78
Printing & Postage	3,505,965	0.55	5,623,876	0.89	2,117,911	0.34
Depreciation & Amortization	5,187,395	0.81	7,195,706	1.14	2,008,311	0.33
Other Expenses	19,290,518	3.02	27,242,967	4.32	7,952,449	1.30
Indirect Cost Allocation, Occupancy	2,510,456	0.39	3,105,241	0.49	594,785	0.10
Total Administrative Expenses	145,245,575	22.72	171,309,235	27.17	26,063,660	4.45
NET INCOME (LOSS) FROM OPERATIONS	48,014,267	7.51	(180,857,303)	(28.69)	228,871,570	36.20
INVESTMENT INCOME						
Interest Income	102,801,914	16.08	46,666,620	7.40	56,135,294	8.68
Realized Gain/(Loss) on Investments	2,459,773	0.38	-	0.00	2,459,773	0.38
Unrealized Gain/(Loss) on Investments	10,682,499	1.67	-	0.00	10,682,499	1.67
Total Investment Income	115,944,186	18.14	46,666,620	7.40	69,277,566	10.74
NET RENTAL INCOME/EXPENSE	(355,949)	(0.06)	(820,960)	(0.13)	465,011	0.07
NET MCO TAX	(1,699)	0.00	-	0.00	(1,699)	0.00
GRANT EXPENSE	(13,356,363)	(2.09)	(8,160,866)	(1.29)	(5,195,497)	(0.80)
OTHER INCOME/EXPENSE	70,850	0.01	-	0.00	70,850	0.01
CHANGE IN NET ASSETS	**150,315,292**	**23.51**	**(143,172,509)**	**(22.71)**	**293,487,801**	**46.22**
MEDICAL LOSS RATIO	**93.2%**		**100.4%**		**(7.2%)**	
ADMINISTRATIVE LOSS RATIO	**5.1%**		**6.9%**		**1.7%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending January 31, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	897,559	17,090		502	533	-	915,151
REVENUES							
Capitation Revenue	$ 357,619,458	$ 36,232,949	$ -	$ 4,623,607	$ 251,059	$ -	$ 398,727,072
Total Operating Revenue	**357,619,458**	**36,232,949**	-	**4,623,607**	**251,059**	-	**398,727,072**
MEDICAL EXPENSES							
Provider Capitation	116,284,008	15,584,301					131,868,310
Claims	128,145,167	6,828,260	(184,151)	1,760,384			136,549,659
MLTSS	41,390,297			4,846	39,371		41,434,514
Prescription Drugs		9,394,377		564,814			9,959,191
Case Mgmt & Other Medical	30,572,074	2,093,597		1,418,137	208,823		34,292,631
Total Medical Expenses	**316,391,546**	**33,900,535**	**(184,151)**	**3,748,181**	**248,194**	-	**354,104,305**
Medical Loss Ratio	*88.5%*	*93.6%*	*0.0%*	*81.1%*	*98.9%*	*0.0%*	*88.8%*
GROSS MARGIN	**41,227,912**	**2,332,414**	**184,151**	**875,426**	**2,864**	-	**44,622,767**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	13,437,746	1,296,770		199,373	122,880		15,056,769
Non-Salary Operating Expenses	3,113,343	776,696		40,292	1,417		3,931,747
Depreciation & Amortization	735,753			1,003			736,756
Other Operating Expenses	3,374,444	219,421		11,672	8,001		3,613,538
Indirect Cost Allocation, Occupancy	(666,034)	1,019,094		16,799	6,639		376,498
Total Administrative Expenses	**19,995,253**	**3,311,981**	-	**269,138**	**138,937**	-	**23,715,309**
Administrative Loss Ratio	*5.6%*	*9.1%*	*0.0%*	*5.8%*	*55.3%*	*0.0%*	*5.9%*
Operating Income/(Loss)	**21,232,659**	**(979,568)**	**184,151**	**606,288**	**(136,073)**	-	**20,907,458**
Investments and Other Non-Operating	(1,994)						14,577,120
CHANGE IN NET ASSETS	**$ 21,230,665**	**$ (979,568)**	**$ 184,151**	**$ 606,288**	**$ (136,073)**	**$ -**	**$ 35,484,578**
BUDGETED CHANGE IN NET ASSETS	(20,192,416)	(1,129,303)	-	(138,399)	(117,924)	(916,666)	(17,124,153)
Variance to Budget - Fav/(Unfav)	$ 41,423,081	$ 149,735	$ 184,151	$ 744,687	$ (18,149)	$ 916,666	$ 52,608,731

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ending January 31, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	6,268,699	120,356	-	3,525	3,522	-	6,392,580
REVENUES							
Capitation Revenue	$ 2,554,971,986	$ 238,295,364	$ (3,197,365)	$ 30,585,384	$ 1,612,134	$ -	$ 2,822,267,503
Total Operating Revenue	**2,554,971,986**	**238,295,364**	**(3,197,365)**	**30,585,384**	**1,612,134**	**-**	**2,822,267,503**
MEDICAL EXPENSES							
Provider Capitation	797,430,624	101,974,263	(1,453,037)				897,951,850
Claims	923,882,801	42,906,351	(184,151)	11,187,791			977,792,792
MLTSS	344,027,689			83,147	260,873		344,371,710
Prescription Drugs		61,609,857		4,117,895			65,727,752
Case Mgmt & Other Medical	322,072,911	10,867,139		8,908,401	1,315,106		343,163,556
Total Medical Expenses	**2,387,414,025**	**217,357,610**	**(1,637,188)**	**24,297,234**	**1,575,979**	**-**	**2,629,007,660**
Medical Loss Ratio	*93.4%*	*91.2%*	*0.0%*	*79.4%*	*97.8%*	*0.0%*	*93.2%*
GROSS MARGIN	**167,557,961**	**20,937,754**	**(1,560,177)**	**6,288,149**	**36,155**	**-**	**193,259,842**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	79,969,756	7,659,276		1,183,775	711,732		89,524,539
Non-Salary Operating Expenses	24,718,086	3,600,259		404,382	9,940		28,732,668
Depreciation & Amortization	5,180,647			6,748			5,187,395
Other Operating Expenses	18,793,863	377,457		65,054	54,145		19,290,518
Indirect Cost Allocation, Occupancy	(5,505,592)	7,838,818		124,654	52,576		2,510,456
Total Administrative Expenses	**123,156,760**	**19,475,809**	**-**	**1,784,612**	**828,394**	**-**	**145,245,575**
Administrative Loss Ratio	*4.8%*	*8.2%*	*0.0%*	*5.8%*	*51.4%*	*0.0%*	*5.1%*
Operating Income/(Loss)	**44,401,201**	**1,461,944**	**(1,560,177)**	**4,503,537**	**(792,239)**	**-**	**48,014,267**
Investments and Other Non-Operating	69,151						102,301,025
CHANGE IN NET ASSETS	**$ 44,470,352**	**$ 1,461,944**	**$ (1,560,177)**	**$ 4,503,537**	**$ (792,239)**	**$ -**	**$ 150,315,292**
BUDGETED CHANGE IN NET ASSETS	(169,662,466)	(8,606,907)	-	(875,151)	(796,113)	(916,666)	(143,172,509)
Variance to Budget - Fav/(Unfav)	$ 214,132,818	$ 10,068,851	$ (1,560,177)	$ 5,378,688	$ 3,874	$ 916,666	$ 293,487,801

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CalOptima Health

Highlights – Consolidated, for Seven Months Ending January 31, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $35.5 million, favorable to budget $52.6 million
- Operating surplus is $20.9 million, with a surplus in non-operating income of $14.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $150.3 million, favorable to budget $293.5 million
- Operating surplus is $48.0 million, with a surplus in non-operating income of $102.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

January 2025				July 2024 - January 2025		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
21.2	(20.2)	41.4	Medi-Cal	44.4	(169.7)	214.1
(1.0)	(1.1)	0.1	OneCare	1.5	(8.6)	10.1
0.6	(0.1)	0.7	PACE	4.5	(0.9)	5.4
(0.1)	(0.1)	0.0	MSSP	(0.8)	(0.8)	0.0
0.2	0.0	0.2	OCC	(1.6)	0.0	(1.6)
0.0	(0.9)	0.9	Covered CA	0.0	(0.9)	0.9
20.9	**(22.5)**	**43.4**	**Total Operating Income (Loss)**	**48.0**	**(180.9)**	**228.9**
			Non-Operating Income (Loss)			
15.4	6.7	8.8	Net Investment Income/Expense	115.9	46.7	69.3
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	0.1	0.0	0.1
14.6	**5.4**	**9.2**	**Total Non-Operating Income/(Loss)**	**102.3**	**37.7**	**64.6**
35.5	**(17.1)**	**52.6**	**TOTAL**	**150.3**	**(143.2)**	**293.5**

CalOptima Health - Consolidated
Enrollment Summary
For the Seven Months Ending January 31, 2025

January 2025					July 2024 - January 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
147,236	137,885	9,351	6.8%	SPD	1,020,028	958,218	61,810	6.5%
265,619	271,904	(6,285)	(2.3%)	TANF Child	1,880,294	1,906,512	(26,218)	(1.4%)
131,708	138,169	(6,461)	(4.7%)	TANF Adult	918,001	965,465	(47,464)	(4.9%)
2,507	2,600	(93)	(3.6%)	LTC	17,429	18,245	(816)	(4.5%)
340,646	322,277	18,369	5.7%	MCE	2,364,937	2,263,266	101,671	4.5%
9,843	9,543	300	3.1%	WCM	68,010	66,913	1,097	1.6%
897,559	**882,378**	**15,181**	**1.7%**	**Medi-Cal Total**	**6,268,699**	**6,178,619**	**90,080**	**1.5%**
17,090	**17,319**	**(229)**	**(1.3%)**	**OneCare**	**120,356**	**121,992**	**(1,636)**	**(1.3%)**
502	**483**	**19**	**3.9%**	**PACE**	**3,525**	**3,327**	**198**	**6.0%**
533	**568**	**(35)**	**(6.2%)**	**MSSP**	**3,522**	**3,976**	**(454)**	**(11.4%)**
0	**0**	**0**	**0.0%**	**Covered CA**	**0**	**0**	**0**	**0.0%**
915,151	**900,180**	**14,971**	**1.7%**	**CalOptima Health Total**	**6,392,580**	**6,303,938**	**88,642**	**1.4%**
				Enrollment (by Network)				
359,631	302,750	56,881	18.8%	HMO	2,244,333	2,122,483	121,850	5.7%
171,663	178,561	(6,898)	(3.9%)	PHC	1,226,073	1,251,933	(25,860)	(2.1%)
68,229	132,486	(64,257)	(48.5%)	Shared Risk Group	778,579	932,099	(153,520)	(16.5%)
298,036	268,581	29,455	11.0%	Fee for Service	2,019,714	1,872,104	147,610	7.9%
897,559	**882,378**	**15,181**	**1.7%**	**Medi-Cal Total**	**6,268,699**	**6,178,619**	**90,080**	**1.5%**
17,090	**17,319**	**(229)**	**(0)**	**OneCare**	**120,356**	**121,992**	**(1,636)**	**(0)**
502	**483**	**19**	**3.9%**	**PACE**	**3,525**	**3,327**	**198**	**6.0%**
533	**568**	**(35)**	**(6.2%)**	**MSSP**	**3,522**	**3,976**	**(454)**	**(11.4%)**
0	**0**	**0**	**0.0%**	**Covered CA**	**0**	**0**	**0**	**0.0%**
915,151	**900,180**	**14,971**	**1.7%**	**CalOptima Health Total**	**6,392,580**	**6,303,938**	**88,642**	**1.4%**

Note:* Total membership does not include MSSP

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610	16,774	20,293	20,211	20,247						127,796	114,775	13,021
TANF Child	66,405	65,921	65,198	64,503	77,875	77,766	77,607						495,275	482,917	12,358
TANF Adult	54,590	55,734	55,056	54,535	70,864	70,611	70,439						431,829	440,542	(8,713)
LTC	2				1		3						6		6
MCE	153,578	153,602	152,129	151,153	190,284	189,645	189,821						1,180,212	1,074,590	105,622
WCM	1,241	1,234	1,214	1,163	1,370	1,479	1,514						9,215	9,659	(444)
Total	292,966	293,002	290,207	288,128	360,687	359,712	359,631						2,244,333	2,122,483	**121,850**
PHCs															
SPD	4,906	4,644	4,820	4,796	4,736	4,780	4,737						33,419	31,579	1,840
TANF Child	140,053	138,903	137,874	136,823	136,101	135,163	133,694						958,611	989,257	(30,646)
TANF Adult	3,994	4,186	4,191	4,104	4,165	4,170	4,132						28,942	34,855	(5,913)
LTC													0		0
MCE	22,999	22,762	22,600	22,551	22,507	22,511	22,520						158,450	151,193	7,257
WCM	6,571	7,308	6,733	6,550	6,336	6,573	6,580						46,651	45,049	1,602
Total	178,523	177,803	176,218	174,824	173,845	173,197	171,663						1,226,073	1,251,933	**(25,860)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133	3,422	3,411	3,353						38,723	45,442	(6,719)
TANF Child	32,783	32,842	32,545	32,325	18,564	18,412	18,308						185,779	220,196	(34,417)
TANF Adult	27,519	29,041	28,870	28,586	11,818	11,756	11,734						149,324	203,090	(53,766)
LTC				1									1	7	(6)
MCE	74,704	74,918	74,517	74,138	34,102	34,260	34,467						401,106	458,220	(57,114)
WCM	702	701	716	707	91	362	367						3,646	5,144	(1,498)
Total	**142,978**	**144,579**	**143,705**	**142,890**	**67,997**	**68,201**	**68,229**						**778,579**	**932,099**	**(153,520)**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297	100,986	101,924	102,883	104,042						710,217	662,893	47,324
TANF Child													0	9	(9)
TANF Adult	1,145	1,159	1,123	1,052	1,035	1,056	1,037						7,607	12,772	(5,165)
LTC	2,178	2,203	2,209	2,222	2,208	2,237	2,234						15,491	16,342	(851)
MCE	4,008	4,703	4,593	4,431	4,388	4,283	4,088						30,494	63,464	(32,970)
WCM	6	7	8	15	12	12	13						73	63	10
Total	**107,630**	**107,864**	**108,230**	**108,706**	**109,567**	**110,471**	**111,414**						**763,882**	**755,543**	**8,339**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868	15,819	15,925	16,332	14,857						109,873	103,529	6,344
TANF Child	32,741	33,377	33,868	33,995	34,269	36,369	36,010						240,629	214,133	26,496
TANF Adult	40,618	42,145	42,625	42,860	43,229	44,456	44,366						300,299	274,206	26,093
LTC	278	254	271	278	285	295	270						1,931	1,896	35
MCE	80,536	82,491	83,546	83,778	84,679	89,895	89,750						594,675	515,799	78,876
WCM	1,205	1,184	1,178	1,114	1,177	1,198	1,369						8,425	6,998	1,427
Total	**171,014**	**174,887**	**177,356**	**177,844**	**179,564**	**188,545**	**186,622**						**1,255,832**	**1,116,561**	**139,271**
Grand Totals															
SPD	145,255	143,460	144,652	145,508	146,300	147,617	147,236						1,020,028	958,218	61,810
TANF Child	271,982	271,043	269,485	267,646	266,809	267,710	265,619						1,880,294	1,906,512	(26,218)
TANF Adult	127,866	132,265	131,865	131,137	131,111	132,049	131,708						918,001	965,465	(47,464)
LTC	2,458	2,457	2,480	2,501	2,494	2,532	2,507						17,429	18,245	(816)
MCE	335,825	338,476	337,385	336,051	335,960	340,594	340,646						2,364,937	2,263,266	101,671
WCM	9,725	10,434	9,849	9,549	8,986	9,624	9,843						68,010	66,913	1,097
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**	**891,660**	**900,126**	**897,559**						**6,268,699**	**6,178,619**	**90,080**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**	**17,156**	**17,037**	**17,090**						**120,356**	**121,992**	**(1,636)**
PACE	**506**	**508**	**503**	**498**	**502**	**506**	**502**						**3,525**	**3,327**	**198**
MSSP	**473**	**480**	**487**	**506**	**524**	**519**	**533**						**3,522**	**3,976**	**(454)**
Covered CA	**0**	**0**	**0**	**0**	**0**	**0**	**0**						**0**	**0**	**0**
Grand Total	**910,928**	**915,950**	**913,501**	**910,063**	**909,318**	**917,669**	**915,151**						**6,392,580**	**6,303,938**	**88,642**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, January enrollment was 915,151

- Favorable to budget 14,971 or 1.7%
- Decreased 2,518 or 0.3% from Prior Month (PM) (December 2024)
- Decreased 19,454 or 2.1% from Prior Year (PY) (January 2024)

Medi-Cal enrollment was 897,559

- Favorable to budget 15,181 or 1.7%
- Medi-Cal Expansion (MCE) favorable to budget 18,369
- Seniors and Persons with Disabilities (SPD) favorable to budget 9,351
- Whole Child Model (WCM) favorable to budget 300
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 12,746
- Long-Term Care (LTC) unfavorable to budget 93
- Decreased 2,567 from PM

OneCare enrollment was 17,090

- Unfavorable to budget 229 or 1.3%
- Increased 53 from PM

PACE enrollment was 502

- Favorable to budget 19 or 3.9%
- Decreased 4 from PM

MSSP enrollment was 533

- Unfavorable to budget 35 or 6.2%
- Increased 14 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
897,559	**882,378**	**15,181**	**1.7%**	**Member Months**	**6,268,699**	**6,178,619**	**90,080**	**1.5%**
				Revenues				
357,619,458	318,736,677	38,882,781	12.2%	Medi-Cal Capitation Revenue	2,554,971,986	2,217,606,284	337,365,702	15.2%
357,619,458	**318,736,677**	**38,882,781**	**12.2%**	**Total Operating Revenue**	**2,554,971,986**	**2,217,606,284**	**337,365,702**	**15.2%**
				Medical Expenses				
116,284,008	111,401,529	(4,882,479)	(4.4%)	Provider Capitation	797,430,624	781,168,773	(16,261,851)	(2.1%)
60,752,334	66,609,366	5,857,032	8.8%	Facilities Claims	464,200,043	457,624,762	(6,575,281)	(1.4%)
67,392,833	68,051,062	658,229	1.0%	Professional Claims	459,682,759	483,053,143	23,370,384	4.8%
41,390,297	49,961,802	8,571,505	17.2%	MLTSS	344,027,689	342,696,917	(1,330,772)	(0.4%)
14,327,458	10,149,756	(4,177,702)	(41.2%)	Incentive Payments	84,823,498	101,183,792	16,360,294	16.2%
8,982,314	9,426,806	444,492	4.7%	Medical Management	59,651,566	63,775,588	4,124,022	6.5%
7,262,302	1,830,208	(5,432,094)	(296.8%)	Other Medical Expenses	177,597,846	12,811,462	(164,786,384)	(1,286.2%)
316,391,546	**317,430,529**	**1,038,983**	**0.3%**	**Total Medical Expenses**	**2,387,414,025**	**2,242,314,437**	**(145,099,588)**	**(6.5%)**
41,227,912	**1,306,148**	**39,921,764**	**3,056.5%**	**Gross Margin**	**167,557,961**	**(24,708,153)**	**192,266,114**	**778.1%**
				Administrative Expenses				
13,437,746	12,530,664	(907,082)	(7.2%)	Salaries, Wages & Employee Benefits	79,969,756	84,582,623	4,612,867	5.5%
1,528,419	1,655,220	126,801	7.7%	Professional Fees	8,521,138	10,483,920	1,962,782	18.7%
1,183,310	2,582,371	1,399,061	54.2%	Purchased Services	13,678,887	16,926,127	3,247,240	19.2%
401,613	527,048	125,435	23.8%	Printing & Postage	2,518,062	3,776,426	1,258,364	33.3%
735,753	1,026,358	290,605	28.3%	Depreciation & Amortization	5,180,647	7,184,506	2,003,859	27.9%
3,374,444	3,783,334	408,889	10.8%	Other Operating Expenses	18,793,863	26,245,728	7,451,865	28.4%
(666,034)	(606,431)	59,603	9.8%	Indirect Cost Allocation, Occupancy	(5,505,592)	(4,245,017)	1,260,575	29.7%
19,995,253	**21,498,564**	**1,503,311**	**7.0%**	**Total Administrative Expenses**	**123,156,760**	**144,954,313**	**21,797,553**	**15.0%**
				Non-Operating Income (Loss)				
(3,398)	-	(3,398)	(100.0%)	Net Operating Tax	(1,699)	-	(1,699)	(100.0%)
1,404	-	1,404	100.0%	Other Income/Expense	70,850	-	70,850	100.0%
(1,994)	**-**	**(1,994)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**69,151**	**-**	**69,151**	**100.0%**
21,230,665	**(20,192,416)**	**41,423,081**	**205.1%**	**Change in Net Assets**	**44,470,352**	**(169,662,466)**	**214,132,818**	**126.2%**
88.5%	***99.6%***	***(11.1%)***		***Medical Loss Ratio***	***93.4%***	***101.1%***	***(7.7%)***	
5.6%	***6.7%***	***1.2%***		***Admin Loss Ratio***	***4.8%***	***6.5%***	***1.7%***	

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MEDI-CAL INCOME STATEMENT– JANUARY MONTH:

REVENUES are $357.6 million, favorable to budget $38.9 million:

- Favorable volume related variance of $5.5 million
- Favorable price related variance of $33.4 million
  - $35.4 million due to favorable Calendar Year (CY) 2025 capitation rates and member mix by the Department of Health Care Services (DHCS)
  - $5.4 million due to recognition of Student Behavioral Health Incentive Program (SBHIP) funding from DHCS
  - Offset by:
    - $7.8 million in Prior Year (PY) revenue adjustment
    - $2.2 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $316.4 million, favorable to budget $1.0 million:

- Unfavorable volume related variance of $5.5 million
- Favorable price related variance of $6.5 million:
  - Managed Long-Term Services and Supports (MLTSS), Facilities Claims and Professional Claims expenses favorable variance of $18.3 million due to lower than expected utilization
  - Medical Management expenses favorable variance of $0.6 million
  - Offset by:
    - Other Medical Expenses unfavorable variance of $5.4 million due primarily to CY 2025 Community Reinvestment and Quality Achievement accruals
    - Incentive Payments expenses unfavorable variance of $4.0 million due primarily to SBHIP payments

ADMINISTRATIVE EXPENSES are $20.0 million, favorable to budget $1.5 million:

- Non-Salary expenses favorable to budget $2.4 million
- Salaries, Wages & Employee Benefits expenses unfavorable to budget $0.9 million

CHANGE IN NET ASSETS is $21.2 million, favorable to budget $41.4 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,090	**17,319**	**(229)**	**(1.3%)**	**Member Months**	**120,356**	**121,992**	**(1,636)**	**(1.3%)**
				Revenues				
26,892,614	26,919,111	(26,497)	(0.1%)	Medicare Part C Revenue	170,963,052	180,005,105	(9,042,053)	(5.0%)
9,340,335	9,433,221	(92,886)	(1.0%)	Medicare Part D Revenue	67,332,311	65,809,732	1,522,579	2.3%
36,232,949	**36,352,332**	**(119,383)**	**(0.3%)**	**Total Operating Revenue**	**238,295,364**	**245,814,837**	**(7,519,473)**	**(3.1%)**
				Medical Expenses				
15,584,301	16,426,240	841,939	5.1%	Provider Capitation	101,974,263	109,926,921	7,952,658	7.2%
4,712,076	4,993,093	281,017	5.6%	Inpatient	29,924,427	34,080,151	4,155,724	12.2%
2,116,184	1,758,034	(358,150)	(20.4%)	Ancillary	12,981,924	12,200,960	(780,964)	(6.4%)
9,394,377	9,098,074	(296,303)	(3.3%)	Prescription Drugs	61,609,857	62,729,755	1,119,898	1.8%
456,327	496,341	40,014	8.1%	Incentive Payments	3,276,764	3,375,679	98,915	2.9%
1,177,790	1,422,074	244,284	17.2%	Medical Management	7,130,894	9,641,333	2,510,439	26.0%
459,480	-	(459,480)	(100.0%)	Other Medical Expenses	459,480	-	(459,480)	(100.0%)
33,900,535	**34,193,856**	**293,321**	**0.9%**	**Total Medical Expenses**	**217,357,610**	**231,954,799**	**14,597,189**	**6.3%**
2,332,414	**2,158,476**	**173,938**	**8.1%**	**Gross Margin**	**20,937,754**	**13,860,038**	**7,077,716**	**51.1%**
				Administrative Expenses				
1,296,770	1,260,799	(35,971)	(2.9%)	Salaries, Wages & Employee Benefits	7,659,276	8,511,065	851,789	10.0%
62,614	121,483	58,869	48.5%	Professional Fees	560,852	811,581	250,729	30.9%
574,107	513,960	(60,147)	(11.7%)	Purchased Services	2,140,827	3,403,540	1,262,713	37.1%
139,975	243,950	103,975	42.6%	Printing & Postage	898,580	1,707,650	809,070	47.4%
219,421	121,504	(97,917)	(80.6%)	Other Operating Expenses	377,457	850,528	473,072	55.6%
1,019,094	1,026,083	6,989	0.7%	Indirect Cost Allocation, Occupancy	7,838,818	7,182,581	(656,237)	(9.1%)
3,311,981	**3,287,779**	**(24,202)**	**(0.7%)**	**Total Administrative Expenses**	**19,475,809**	**22,466,945**	**2,991,136**	**13.3%**
(979,568)	**(1,129,303)**	**149,735**	**13.3%**	**Change in Net Assets**	**1,461,944**	**(8,606,907)**	**10,068,851**	**117.0%**
93.6%	***94.1%***	***(0.5%)***		***Medical Loss Ratio***	***91.2%***	***94.4%***	***(3.1%)***	
9.1%	***9.0%***	***(0.1%)***		***Admin Loss Ratio***	***8.2%***	***9.1%***	***1.0%***	

ONECARE INCOME STATEMENT– JANUARY MONTH:

REVENUES are $36.2 million, unfavorable to budget $0.1 million:

- Unfavorable volume related variance of $0.5 million
- Favorable price related variance of $0.4 million

MEDICAL EXPENSES are $33.9 million, favorable to budget $0.3 million:

- Favorable volume related variance of $0.5 million
- Unfavorable price related variance of $0.2 million

ADMINISTRATIVE EXPENSES are $3.3 million, unfavorable to budget $24,202:

- Salaries, Wages & Employee Benefits expenses unfavorable to budget $35,971
- Non-Salary expenses favorable to budget $11,769

CHANGE IN NET ASSETS is ($1.0) million, favorable to budget $0.1 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
502	**483**	**19**	**3.9%**	**Member Months**	**3,525**	**3,327**	**198**	**6.0%**
				Revenues				
3,473,267	3,028,520	444,747	14.7%	Medi-Cal Capitation Revenue	22,946,848	20,892,101	2,054,747	9.8%
839,597	794,518	45,079	5.7%	Medicare Part C Revenue	5,373,499	5,089,122	284,377	5.6%
310,743	246,320	64,423	26.2%	Medicare Part D Revenue	2,265,037	1,668,762	596,275	35.7%
4,623,607	**4,069,358**	**554,249**	**13.6%**	**Total Operating Revenue**	**30,585,384**	**27,649,985**	**2,935,399**	**10.6%**
				Medical Expenses				
1,418,137	1,418,644	507	0.0%	Medical Management	8,908,401	9,605,894	697,493	7.3%
765,210	768,354	3,144	0.4%	Facilities Claims	4,898,883	5,220,276	321,393	6.2%
696,605	848,823	152,218	17.9%	Professional Claims	4,645,965	5,758,641	1,112,676	19.3%
564,814	569,807	4,993	0.9%	Prescription Drugs	4,117,895	3,838,453	(279,442)	(7.3%)
4,846	36,708	31,862	86.8%	MLTSS	83,147	192,977	109,830	56.9%
298,569	260,447	(38,122)	(14.6%)	Patient Transportation	1,642,943	1,823,129	180,186	9.9%
3,748,181	**3,902,783**	**154,603**	**4.0%**	**Total Medical Expenses**	**24,297,234**	**26,439,370**	**2,142,136**	**8.1%**
875,426	**166,575**	**708,851**	**425.5%**	**Gross Margin**	**6,288,149**	**1,210,615**	**5,077,534**	**419.4%**
				Administrative Expenses				
199,373	180,622	(18,751)	(10.4%)	Salaries, Wages & Employee Benefits	1,183,775	1,216,472	32,697	2.7%
2,292	8,708	6,416	73.7%	Professional Fees	15,017	61,256	46,239	75.5%
43,093	70,533	27,440	38.9%	Purchased Services	300,043	451,731	151,688	33.6%
(5,093)	13,900	18,993	136.6%	Printing & Postage	89,322	139,800	50,478	36.1%
1,003	1,600	597	37.3%	Depreciation & Amortization	6,748	11,200	4,452	39.8%
11,672	12,823	1,151	9.0%	Other Operating Expenses	65,054	88,961	23,907	26.9%
16,799	16,788	(11)	(0.1%)	Indirect Cost Allocation, Occupancy	124,654	116,346	(8,308)	(7.1%)
269,138	**304,974**	**35,836**	**11.8%**	**Total Administrative Expenses**	**1,784,612**	**2,085,766**	**301,154**	**14.4%**
606,288	**(138,399)**	**744,687**	**538.1%**	**Change in Net Assets**	**4,503,537**	**(875,151)**	**5,378,688**	**614.6%**
81.1%	***95.9%***	***(14.8%)***		***Medical Loss Ratio***	***79.4%***	***95.6%***	***(16.2%)***	
5.8%	***7.5%***	***1.7%***		***Admin Loss Ratio***	***5.8%***	***7.5%***	***1.7%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
533	**568**	**(35)**	**(6.2%)**	**Member Months**	**3,522**	**3,976**	**(454)**	**(11.4%)**
				Revenues				
251,059	253,517	(2,458)	(1.0%)	Revenue	1,612,134	1,774,619	(162,485)	(9.2%)
251,059	**253,517**	**(2,458)**	**(1.0%)**	**Total Operating Revenue**	**1,612,134**	**1,774,619**	**(162,485)**	**(9.2%)**
				Medical Expenses				
208,823	207,784	(1,039)	(0.5%)	Medical Management	1,315,106	1,454,488	139,382	9.6%
39,371	32,957	(6,414)	(19.5%)	Waiver Services	260,873	230,699	(30,174)	(13.1%)
208,823	207,784	(1,039)	(0.5%)	Total Medical Management	1,315,106	1,454,488	139,382	9.6%
39,371	32,957	(6,414)	(19.5%)	Total Waiver Services	260,873	230,699	(30,174)	(13.1%)
248,194	**240,741**	**(7,453)**	**(3.1%)**	**Total Program Expenses**	**1,575,979**	**1,685,187**	**109,208**	**6.5%**
2,864	**12,776**	**(9,912)**	**(77.6%)**	**Gross Margin**	**36,155**	**89,432**	**(53,277)**	**(59.6%)**
				Administrative Expenses				
122,880	113,700	(9,180)	(8.1%)	Salaries, Wages & Employee Benefits	711,732	766,545	54,813	7.2%
1,417	1,417	0	0.0%	Professional Fees	9,917	9,919	2	0.0%
-	-	-	0.0%	Purchased Services	24	-	(24)	(100.0%)
8,001	8,250	249	3.0%	Other Operating Expenses	54,145	57,750	3,605	6.2%
6,639	7,333	694	9.5%	Indirect Cost Allocation, Occupancy	52,576	51,331	(1,245)	(2.4%)
138,937	**130,700**	**(8,237)**	**(6.3%)**	**Total Administrative Expenses**	**828,394**	**885,545**	**57,151**	**6.5%**
(136,073)	**(117,924)**	**(18,149)**	**(15.4%)**	**Change in Net Assets**	**(792,239)**	**(796,113)**	**3,874**	**0.5%**
98.9%	***95.0%***	***3.9%***		***Medical Loss Ratio***	***97.8%***	***95.0%***	***2.8%***	
55.3%	***51.6%***	***(3.8%)***		***Admin Loss Ratio***	***51.4%***	***49.9%***	***(1.5%)***	

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CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medicare Part C Revenue	(3,197,365)	-	(3,197,365)	(100.0%)
-	-	-	**0.0%**	**Total Operating Revenue**	**(3,197,365)**	-	**(3,197,365)**	**(100.0%)**
				Medical Expenses				
-	-	-	0.0%	Provider Capitation	(1,453,037)	-	1,453,037	100.0%
(184,151)	-	184,151	100.0%	Facilities Claims	(184,151)	-	184,151	100.0%
(184,151)	**-**	**184,151**	**100.0%**	**Total Medical Expenses**	**(1,637,188)**	**-**	**1,637,188**	**100.0%**
184,151	-	**184,151**	**100.0%**	**Gross Margin**	**(1,560,177)**	-	**(1,560,177)**	**(100.0%)**
				Administrative Expenses				
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
184,151	-	**184,151**	**100.0%**	**Change in Net Assets**	**(1,560,177)**	-	**(1,560,177)**	**(100.0%)**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***51.2%***	***0.0%***	***51.2%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Medical Expenses				
-	-	-	**0.0%**	**Total Medical Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Gross Margin**	-	-	-	**0.0%**
				Administrative Expenses				
-	916,666	916,666	100.0%	Professional Fees	-	916,666	916,666	100.0%
-	**916,666**	**916,666**	**100.0%**	**Total Administrative Expenses**	-	**916,666**	**916,666**	**100.0%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	-	-	**0.0%**	**Total Non-Operating Income (Loss)**	-	-	-	**0.0%**
-	**(916,666)**	**916,666**	**(100.0%)**	**Change in Net Assets**	-	**(916,666)**	**916,666**	**(100.0%)**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

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CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
51,419	22,905	(28,514)	(124.5%)	Purchased Services	348,265	160,335	(187,930)	(117.2%)
181,030	195,000	13,970	7.2%	Depreciation & Amortization	1,266,478	1,365,000	98,522	7.2%
24,795	26,654	1,859	7.0%	Insurance Expense	173,199	186,578	13,379	7.2%
130,914	181,186	50,272	27.7%	Repair & Maintenance	823,044	1,268,302	445,258	35.1%
40,524	56,824	16,300	28.7%	Other Operating Expenses	430,583	397,768	(32,815)	(8.2%)
(428,681)	(482,569)	(53,888)	(11.2%)	Indirect Cost Allocation, Occupancy	(3,041,570)	(3,377,983)	(336,413)	(10.0%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	135,866	20,557	15.1%	Rental Income	1,094,963	951,062	143,901	15.1%
156,423	**135,866**	**20,557**	**15.1%**	**Total Operating Revenue**	**1,094,963**	**951,062**	**143,901**	**15.1%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
46,169	9,330	(36,839)	(394.8%)	Purchased Services	287,630	65,310	(222,320)	(340.4%)
58,789	51,000	(7,789)	(15.3%)	Depreciation & Amortization	374,185	357,000	(17,185)	(4.8%)
8,226	8,746	520	6.0%	Insurance Expense	57,850	61,222	3,372	5.5%
44,664	94,592	49,928	52.8%	Repair & Maintenance	384,741	662,144	277,403	41.9%
(3,510)	25,978	29,488	113.5%	Other Operating Expenses	185,976	181,846	(4,130)	(2.3%)
(18,384)	-	18,384	100.0%	Indirect Cost Allocation, Occupancy	(136,653)	-	136,653	100.0%
135,953	**189,646**	**53,693**	**28.3%**	**Total Administrative Expenses**	**1,153,727**	**1,327,522**	**173,795**	**13.1%**
20,471	**(53,780)**	**74,251**	**138.1%**	**Change in Net Assets**	**(58,764)**	**(376,460)**	**317,696**	**84.4%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
29,702	42,500	12,798	30.1%	Purchased Services	190,467	297,500	107,033	36.0%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	65,782	147,000	81,218	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	32,247	-	(32,247)	(100.0%)
298	-	(298)	(100.0%)	Repair & Maintenance	1,583	-	(1,583)	(100.0%)
367	-	(367)	(100.0%)	Other Operating Expenses	7,106	-	(7,106)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
44,515	**63,500**	**18,985**	**29.9%**	**Total Administrative Expenses**	**297,185**	**444,500**	**147,315**	**33.1%**
(44,515)	**(63,500)**	**18,985**	**29.9%**	**Change in Net Assets**	**(297,185)**	**(444,500)**	**147,315**	**33.1%**

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OTHER PROGRAM INCOME STATEMENTS – JANUARY MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.6 million, favorable to budget $0.7 million

MSSP

- **CHANGE IN NET ASSETS** is ($136,073), unfavorable to budget $18,149

OneCare Connect

- **CHANGE IN NET ASSETS** is $184,151, favorable to budget $184,151

Covered CA

- **CHANGE IN NET ASSETS** is $0, favorable to budget $0.9 million

NON-OPERATING INCOME STATEMENTS – JANUARY MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $20,471, favorable to budget $74,251
  - Net of $156,423 in rental income and $135,953 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($44,515), favorable to budget $18,985

INVESTMENT INCOME

- Favorable variance of $8.8 million due to $7.5 million of interest income and $1.2 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
January 31, 2025

		January-25	December-24	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	470,286,895	688,117,507	(217,830,611)	(31.7%)
	Short-term Investments	1,717,421,060	1,757,022,283	(39,601,223)	(2.3%)
	Capitation Receivable	728,404,881	685,650,501	42,754,380	6.2%
	Receivables - Other	97,673,244	95,208,691	2,464,553	2.6%
	Prepaid Expenses	13,759,190	14,803,823	(1,044,632)	(7.1%)
	Total Current Assets	**3,027,545,271**	**3,240,802,805**	**(213,257,534)**	**(6.6%)**
Board Designated Assets					
	Board Designated Reserves	1,091,569,915	1,036,698,175	54,871,739	5.3%
	Statutory Designated Reserves	136,311,403	135,603,541	707,862	0.5%
	Total Designated Assets	**1,227,881,318**	**1,172,301,716**	**55,579,601**	**4.7%**
Restricted Deposit		**300,000**	**300,000**	-	**0.0%**
Capital Assets, Net		**101,508,156**	**102,133,678**	**(625,523)**	**(0.6%)**
Total Assets		**4,357,234,744**	**4,515,538,199**	**(158,303,455)**	**(3.5%)**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,549,290	24,549,290	-	0.0%
	Other Postemployment Benefits	1,350,000	1,350,000	-	0.0%
	Total Deferred Outflows of Resources	**75,899,007**	**75,899,007**	-	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**4,433,133,751**	**4,591,437,206**	**(158,303,455)**	**(3.4%)**
LIABILITIES					
Current Liabilities					
	Accounts Payable	351,118,555	410,582,067	(59,463,512)	(14.5%)
	Medical Claims Liability	1,070,061,981	1,240,732,265	(170,670,284)	(13.8%)
	Accrued Payroll Liabilities	23,142,071	26,697,567	(3,555,495)	(13.3%)
	Deferred Revenue	44,342,333	14,309,427	30,032,906	209.9%
	Other Current Liabilities	-	-	-	0.0%
	Capitation & Withholds	128,169,083	122,901,380	5,267,703	4.3%
	Total Current Liabilities	**1,616,834,023**	**1,815,222,705**	**(198,388,682)**	**(10.9%)**
GASB 96 Subscription Liabilities		20,237,234	21,301,538	(1,064,304)	(5.0%)
Community Reinvestment		128,162,741	122,500,439	5,662,302	4.6%
Capital Lease Payable		266,593	270,397	(3,804)	(1.4%)
Postemployment Health Care Plan		17,607,889	17,601,435	6,454	0.0%
Net Pension Liability		45,981,359	45,981,359	-	0.0%
Total Liabilities		**1,829,089,839**	**2,022,877,873**	**(193,788,033)**	**(9.6%)**
Deferred Inflows of Resources					
	Net Pension	2,248,445	2,248,445	-	0.0%
	Other Postemployment Benefits	6,398,000	6,398,000	-	0.0%
	Total Deferred Inflows of Resources	**8,646,445**	**8,646,445**	-	**0.0%**
Net Position					
	Required TNE	129,294,670	130,121,242	(826,572)	(0.6%)
	Funds in excess of TNE	2,466,102,797	2,429,791,647	36,311,150	1.5%
	Total Net Position	**2,595,397,467**	**2,559,912,889**	**35,484,578**	**1.4%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,433,133,751**	**4,591,437,206**	**(158,303,455)**	**(3.4%)**

BALANCE SHEET – JANUARY MONTH:

ASSETS of $4.4 billion decreased $158.3 million from December or 3.4%

- Operating Cash and Short-term Investments net decrease of $257.4 million due to
  - Payments for CY 2023 Intergovernmental Transfers (IGT)13 of $159.0 million
  - Quarterly Managed Care Organization (MCO) tax payment of $125.4 million
  - Transfer of $50.0 million to Board Designated Reserves - Tier One Investment Accounts
  - Additional payroll of $6.5 million
  - Payment for Targeted Provider Rate Increase (TRI) of $4.2 million
  - Payment for SBHIP of $2.9 million
  - Offset by receipt of the January and February Centers for Medicare & Medicaid Services (CMS) payments of $67.3 million and one less Facets claim payments check run
- Board Designated Reserves increased $55.6 million due to the transfer of $50.0 million from Operating Cash
- Capitation Receivables increased $42.8 million due to the timing of cash receipts

LIABILITIES of $1.8 billion decreased $193.8 million from December or 9.6%

- Medical Claims Liabilities decreased $170.7 million due primarily to timing of CY 2023 IGT payments
- Accounts Payable decreased $59.5 million due primarily to the timing of quarterly MCO tax payment and higher accruals corresponding to higher rates
- Deferred Revenue increased $30.0 million due to the receipt of the February capitation checks from CMS

NET ASSETS of $2.6 billion, increased $35.5 million from December or 1.4%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of January 31, 2025

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	545,821,093				
MetLife Tier One	545,748,822				
Board Designated Reserves	1,091,569,915	934,101,583	1,120,921,899	157,468,332	(29,351,985)
Current Reserve Level (X months of average monthly revenue) [1]	*2.92*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,263,488				
MetLife Tier Two	68,047,915				
Statutory Designated Reserves	136,311,403	129,294,670	142,224,137	7,016,733	(5,912,734)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

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

CalOptima Health
Statement of Cash Flow
January 31, 2025

	January 2025	July 2024 - January 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	35,484,578	150,315,292
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	985,972	6,893,840
Changes in assets and liabilities:		
Prepaid expenses and other	1,044,632	(2,590,071)
Capitation receivable	(45,218,933)	(271,391,642)
Medical claims liability	(170,670,284)	(81,782,144)
Deferred revenue	30,032,906	29,081,170
Payable to health networks	5,267,703	(48,064,611)
Accounts payable	(59,463,512)	178,798,948
Accrued payroll	(3,549,041)	(2,506,708)
Other accrued liabilities	4,594,194	25,017,690
Net cash provided by/(used in) operating activities	(201,491,784)	(16,228,234)
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	39,601,223	60,474,880
Change in Property and Equipment	(360,450)	(11,841,188)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(55,579,601)	(90,117,880)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(16,338,828)	(41,484,188)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(217,830,611)	(57,712,422)
CASH AND CASH EQUIVALENTS, beginning of period	688,117,507	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**470,286,895**	**470,286,895**

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CalOptima Health
Spending Plan
For the Seven Months Ending January 31, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 1/31/2025	**$2,595.4**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,091.6**			**42.1%**
	Statutory Designated Reserve[1]	**$136.3**			**5.3%**
	Capital Assets, net of Depreciation[2]	**$101.5**			**3.9%**
Resources Allocated[3]	Homeless Health Initiative[3]	$16.0	$61.7	$45.7	0.6%
	Housing and Homelessness Incentive Program[3]	22.1	87.4	65.3	0.9%
	Intergovernmental Transfers (IGT)	54.5	111.7	57.2	2.1%
	Digital Transformation and Workplace Modernization[4]	43.2	100.0	56.8	1.7%
	Mind OC Grant (Orange)	0.1	1.0	0.9	0.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.8%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.2	4.7	3.5	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	127.1	153.5	26.4	4.9%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.8	50.0	5.2	1.7%
	Distribution Event - Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	6.3	107.5	101.2	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	4.0	7.6	3.6	0.2%
	Quality Initiatives from unearned Pay for Value Program	19.2	23.3	4.1	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	403.4	526.2	122.8	15.5%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	Subtotal:	**$855.3**	**$1,422.6**	**$567.2**	**33.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$410.7**			**15.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 142 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health
Key Financial Indicators
As of January 31, 2025

	Item Name	December 2024 Actual	Budget	Variance	%		July - December 2024 Actual	Budget	Variance	%	
Income Statement	Member Months	915,151	900,180	14,971	1.7%		6,392,580	6,303,938	88,642	1.4%	
	Operating Revenue	398,727,072	359,411,884	39,315,188	10.9%		2,822,267,503	2,492,845,725	329,421,778	13.2%	
	Medical Expenses	354,104,305	355,767,909	1,663,604	0.5%		2,629,007,660	2,502,393,793	(126,613,867)	(5.1%)	
	General and Administrative Expense	23,715,309	26,138,683	2,423,374	9.3%		145,245,575	171,309,235	26,063,660	15.2%	
	Non-Operating Income/(Loss)	14,577,120	5,370,555	9,206,565	171.4%		102,301,025	37,684,794	64,616,231	171.5%	
	Summary of Income & Expenses	35,484,578	(17,124,153)	52,608,731	307.2%		150,315,292	(143,172,509)	293,487,801	205.0%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	88.8%	99.0%	(10.2%)			93.2%	100.4%	(7.2%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	5.9%	7.3%	1.3%			5.1%	6.9%	1.7%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@1/31/2025*	2,921,329,201	2,905,940,415	15,388,786	0.5%

Unallocated/Unassigned Reserve Balance	Current Month @ January 2025	Fiscal Year Ending June 2024	Change	%
Consolidated	410,667,852	187,643,914	223,023,938	118.9%
*Days Cash On Hand**	142			

*Total Designated Reserves and unallocated reserve amount can support approximately 142 days of CalOptima Health's current operations.

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CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Seven Months Ending January 31, 2025

	January 2025				July 2024 - January 2025				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**635,065**	**586,246**	**(48,819)**	**(8.3%)**	**3,608,164**	**1,670,736**	**(1,937,428)**	**(116.0%)**	**12,051,024**	**25,734,445**	**13,683,421**	**53.2%**
Operating Expenses:												
Salaries, Wages & Benefits	591,093	589,848	(1,245)	(0.2%)	4,077,296	4,128,936	51,640	1.3%	15,083,563	15,135,203	51,640	0.3%
Professional Fees	513,387	519,319	5,932	1.1%	3,502,283	3,645,903	143,620	3.9%	5,263,346	5,406,965	143,620	2.7%
Purchased Services	5,365	142,000	136,635	96.2%	129,062	994,000	864,938	87.0%	279,062	1,144,000	864,938	75.6%
GASB 96 Amortization Expenses	55,287	293,417	238,130	81.2%	336,554	2,053,919	1,717,365	83.6%	2,307,757	4,025,122	1,717,365	42.7%
Other Expenses	595,248	751,444	156,196	20.8%	3,913,645	5,249,438	1,335,794	25.4%	17,443,137	18,778,930	1,335,794	7.1%
Medical Management	229,257	-	(229,257)	0.0%	1,604,796	-	(1,604,796)	0.0%	4,355,874	2,751,078	(1,604,796)	(58.3%)
Total Operating Expenses	**1,989,637**	**2,296,028**	**306,391**	**13.3%**	**13,563,636**	**16,072,196**	**2,508,560**	**15.6%**	**44,732,739**	**47,241,299**	**2,508,560**	**5.3%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	12,051,024	19,474,685
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	13,563,636	13,988,699
Ending Funding Balance	**9,752,853**	**43,216,236**	**33,463,383**
Add: Prior year unspent Operating Budget	-		
Total Available Funding	**9,752,853**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
Note: On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

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CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of January 31, 2025

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	871,058	92,203
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,883,740	6,005,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	7,327,227	2,749,425
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$45,740,977**	**$56,059,023**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$45,740,977**	**$15,959,023**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of January 31, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	28,988,750	25,942,244	18,000,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,316,753	22,067,777	-
Total	**160,315,719**	**142,315,524**	**94,305,503**	**48,010,021**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	824,600	575,400	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,021,311	1,600,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	508,429	191,571	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$94,005,502**	**$39,180,023**	

Notes:
[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health
Budget Allocation Changes
Reporting Changes as of January 31, 2025

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	To reallocate funds from ITS - Applications Management - System Development Enhancement for CalAIM to Care Management System – ZeOmega JIVA for reporting post Go Live.	2024-25
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To reallocate funds from Accounting - Purchased Services to Accounting – Printing and Postage to provide additional funding for toner purchase.	2024-25
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To reallocate funds from ITS - Infrastructure - Maintenance HW/SW - Server - VMWare to IT Service Management to address additional licensing needs and increased costs for the Impact Guide.	2024-25
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To reallocate funds from ITS - Applications Management - Salesforce CRM to Crowe Subscription License Fee to provide funding needed for its licensing.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Network Bandwidth Upgrade for All Sites (Wide Area Network) due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Digital Transformation Strategy Planning and Execution Support due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Clinical Data Sets Quality Assurance & Data Aggregator Validation due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	To reallocate funds from ITS - Application Development - Veracode Code Scanning to Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues.	2024-25
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To reallocate funds from Communications - Advertising - Outdoor to Professional Fees to provide additional funding for Runyon Saltzman for Marketing.	2024-25
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	To reallocate funds from ITS - Applications Management - HW/SW Maintenance to Executive Office - Professional Dues for coverage of expenses.	2024-25
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To reallocate funds from Accounting - Change Health Care - Claims Processing/Mailing to Office Supplies to provide additional funding needed to replenish check stock.	2024-25
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To reallocate funds from PACE Administrative - DHCS Annual Fee to Subscriptions to provide funding for DHCS PACE Licensing Fees.	2024-25
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To reallocate funds from ITS - Application Development - Capital Software Expense to ITS - Applications Management - HealthEdge to help pay for Guiding Care Read Only invoice.	2024-25
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To reallocate funds from Sales & Marketings - Purchased Services - General to ITS - Applications Management – Enthrive to engage Enthrive for additional builds to the agent portal.	2024-25
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To reallocate funds from ITS - Infrastructure - MSFT Azure Assistance to Delphix - Continuous Data FACETS to cover the renewal subscription being higher than the anticipated amount.	2024-25
November	PACE	PACE Marketing - Member Communication	PACE Marketing - Advertising	$84,000	To reallocate funds from PACE Marketing - Printing and Postage to Purchased Services to provide additional funding needed for advertisement extension.	2024-25
December	Medi-Cal	Executive Office - Professional Fees	Executive Office - Professioanl Dues	$30,000	To reallocate fund from Executive Office - Professional Fees to Other Operating Expenses - Professional Dues for the Center for Corporate Innovation Membership due.	2024-25
January	Medi-Cal	Medical Management - Professional Fees	Medical Management - Other Operating Expenses - Training & Seminars	$40,000	To reallocate funds from Medical Management - Professional Fees to Other Operating Expenses - Training & Seminars for the Mandatory DHCS Training.	2024-25
January	OneCare	Quality Analytics - Purchased Services	Case Management - Purchased Services	$50,000	To reallocate funds from Quality Analytics - Purchase Services to Case Management - Purchase Services for the OC Members Health Education training.	2024-25
January	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$20,000	To reallocate funds from IS - Application Development - Other Operating Expenses - HW/SW Maintenance to IS - Application Management - Other Operating Expenses - HW/SW Maintenance for additional Subscription License fees.	2024-25
January	Medi-Cal	IS - Application Development - Human Resources Electronic Record System	IS - Application Development - Human Resources Capital Management Solution Software	$40,000	To reallocate funds from IS - Application Development - Human Resources Electronic Record System project to Human Resources Capital Management Solution Software project due to project schedule extension.	2024-25
January	Medi-Cal	IS - Application Development - Human Capital Management Integration	IS - Application Development - Human Resources Capital Management Solution Software	$63,000	To reallocate funds from IS - Application Development - Human Capital Management Integration project to Human Resources Capital Management Solution Software project due to project schedule extension.	2024-25
January	Medi-Cal	IS - Infrastructure - Compliance and Risk Management System	IS - Infrastructure - Technology Asset Inventory Tracking Application	$100,000	To reallocate funds from IS - Infrastructure - Compliance and Risk Management System project to Technology Asset Inventory Tracking Application for addition of Service Mapping and Cloud Discovery for ServiceNow.	2024-25
January	Medi-Cal	Claims Administration - Purchased Services	ITS - Applications Management - Professional Fees	$27,000	To reallocate funds from Claims Administration - Purchased Services - General to ITS - Applications Management - Professional Fees for Moss Adams additional Audit Tool customization/enhancements.	2024-25
January	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$48,000	To reallocate funds from ITS - Applications Management - Professional Fees to Other Operating Expenses - Maintenance HW/SW for Moss Adams Audit Tools.	2024-25

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
March 6, 2025

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. Medicare

a. **2025 Department of Managed Care (DMHC) Routine Financial Examination:**

Update

- Audit sessions have been completed as of January 31, 2025, and DMHC is in the process of concluding the audit.
- The Plan representation letter is expected to be received after February 10, 2025.

Previously Reported

- Pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act, the DMHC is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan.
- The purpose of the financial examinations is to evaluate and report on regulatory compliance with the Knox Keene Act. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions.
- September 5, 2024 – the DMHC engaged CalOptima Health for the 2025 DMHC Routine Examination.
  - The examination will be of the Plan's fiscal and administrative affairs, including an examination of CalOptima Health's financial reports.
- December 16, 2024 – Pre-audit deliverables due to DMHC.
- January 13, 2025 – Examination to commence and will be conducted remotely via audio/video conference.

b. **2025 Centers for Medicare & Medicaid Services (CMS) Readiness Checklist *(applicable to OneCare)***

Update

- Regulatory Affairs and Compliance (RAC) Medicare is leading the 2025 Readiness Checklist activities with all applicable departments to ensure compliance with requirements impacting their respective operational area(s).

Back to Agenda

- Pending validation on one element in order to close out the audit activity. The validation audit activities are expected to conclude by mid-February.

Previously Reported -- Background

- The 2025 CMS Readiness Checklist summarized a subset of key operational requirements solely for the purpose of providing a tool to be used in preparation for the upcoming year. It does not supersede requirements established in statutes or regulations as they related to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), 1876 Cost Plans and the Program of All-inclusive Care for the Elderly (PACE). CMS recommends that organizations review this checklist and take necessary steps to fulfill requirements for CY 2025.

c. **2025 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OneCare)***

Update

- January 29, 2025 – Part C and Part D Grievance reporting measures were submitted to CMS.
- The remaining Part C and Part D reporting measures are in progress and will be submitted no later than the regulatory deadline of February 24, 2025:
  - Organization Determinations and Reconsiderations (ODR)
  - Special Needs Plan (SNP) Care Management
  - Medication Therapy Management Programs (MTMP)
  - Improving Drug Utilization Review (IDUR)
  - Coverage Determinations and Redeterminations

d. **Triennial Network Adequacy Review (*applicable to OneCare)***

Previously Reported

- December 5, 2024 – CalOptima Health received notification that the OneCare contract (H5433) has been selected for the CMS Three-Year Provider Network Adequacy Review.
- The formal review will begin in June 2025.

Previously Reported -- Background

- Medicare Advantage organizations are required to maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served.
- If CMS finds deficiencies in the contract's provider or facility network, the contract may be subject to compliance action.

e. **2023 Medicare Part D Improper Payment Measure (IPM)**

Update

- January 10, 2025 – CMS selected contract H5433 for the inclusion in the CY 2023 Medicare Part IPM.
- One prescription drug event (PDE) was selected.
- CalOptima Health has set an internal deadline of March 4, 2025 in order to meet the regulatory early submission deadline of March 7, 2025.

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- The submission window is now open through April 18, 2025.

Background

The Medicare Part D IPM is conducted to validate the accuracy of the PDE data submitted by Medicare Part D sponsors to CMS for CY 2023 payments. The results of these activities will be used to calculate a national program-wide improper payment rate for Medicare Part D.

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- January 27, 2025, through January 29, 2025 – DHCS was onsite to interview CalOptima Health staff.
- DHCS initially planned to be onsite through February 7, 2025, however, determined that no follow-up sessions were needed.
- The Regulatory Affairs and Compliance (RAC) Medi-Cal team continues to coordinate and respond to DHCS's requests in follow-up to their onsite visit.
- February 7, 2025 – DHCS will hosted a preliminary exit conference via webinar.
  - Six preliminary findings were communicated during the exit conference
- Anticipated Next Steps:
  - In approximately two to three months DHCS will send a draft audit report to CalOptima Health, which will be three (3) business days prior to the formal Exit Conference (date is to be determined).
  - During the Exit Conference, DHCS will explain the findings, and give CalOptima Health an opportunity to ask questions.
  - If CalOptima Health has any statements to express or wants to submit additional information, CalOptima Health must submit the response to DHCS, in writing, within 15 calendar days from date of the Exit Conference.

Previously Reported

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit will consist of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    - Utilization management
    - Case management and coordination of care
      - New area to be audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area to be audited in this category:
        - Encounters
  - New areas to be audited
    - Enhanced Care Management (ECM)
    - Encounters

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- The audit is considered a limited-scope audit and requires the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
- Onsite interviews will be conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
- The audit will involve a review of pre-onsite documents, staff interviews and medical record review.

➢ January 27, 2025 through February 7, 2025 – DHCS begin the onsite visit with an Entrance Conference and conduct staff interviews throughout the rest of the onsite visit.

b. 2024 DHCS Routine Medical Audit

Update

➢ DHCS provided a response on January 31, 2025, accepting 9 of the 10 CAPs.
- The remaining CAP was pending evidence of a monitoring report, which was submitted to DHCS on February 5, 2025.

➢ CalOptima Health is awaiting DHCS review of the final scheduled deliverable.

Previously Reported

➢ August 22, 2024 – CalOptima Health received a formal request for corrective action plan (CAP) from DHCS.

➢ September 23, 2024 – CalOptima Health provided its timely Corrective Action Plan (CAP) submission to DHCS.
- CalOptima Health is required to submit monthly updates, on the 15th of each month, to DHCS until the final CAP deliverable is completed.
- Final CAP deliverable is scheduled to be completed by January 2025
  - October 15, 2024 – CalOptima Health provided its first monthly update to DHCS following the initial CAP submission in September.

➢ For background the DHCS Routine Medical Audit consists of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The findings are as follows:
- Primary/Main Contract
  - Draft & Final Report Identified **10 Findings**
- Secondary Contract - State Supported Services (SSS)
  - Draft & Final Report Identified **No Findings**

c. Managed Care Accountability Set (MCAS) Requirements – DHCS Notice to Collect Sanctions

➢ As previously reported, on January 13, 2023, the DHCS issued a Notice of Imposition of Monetary Sanctions to CalOptima Health for failure to meet two (2) required minimum performance levels (MPLs) for measurement year (MY) 2021, MCAS performance measures.

➢ On January 27, 2025, CalOptima Health was notified that DHCS would proceed with collecting monetary sanctions.

➢ In subsequent reporting of MCAS measures for MY 2022 and MY 2023, CalOptima Health has remained compliant with no sanctions issued.

➢ CalOptima Health anticipates information on MY 2024 in Q4 of 2025.

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B. Regulatory Notices of Non-Compliance

- January 17, 2025 – CMS issued a Warning Letter to CalOptima Health for failure to comply with contract year (CY) 2025 Part D bid submission requirements. Organizations were responsible for ensuring that complete and accurate CY 2025 bids were submitted by June 3, 2024.
- The Part D portion of CalOptima Health's contract H5433 initial bid failed to constitute a complete and accurate bid submission.
- A Corrective Action Plan was issued to Pharmacy Management with a due date of February 5, 2025.

C. Updates on Health Network Monitoring and Audits

a. Health Network Audits

- CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
  - None to Report

D. Internal Audit Department (IAD)

a. Internal Audits in Progress

- 2024 Utilization Management (UM) (OneCare) Annual Audit
- 2024 Utilization Management (Medi-Cal) Annual Audit
- 2024 Behavioral Health (BH) (Medi-Cal) Department Annual Audit
- 2024 Pharmacy (Medi-Cal) Annual Audit
- Pharmacy (OneCare) Annual Audit
- 2024 Grievance & Appeals Resolution (GARS) Department (CDAG-OneCare)

b. Board-Approved Initiatives Review

Update

Grants currently under review include:

- Be Well/Mind OC, Irvine
- Housing for Health Orange County
  - Grant is closed
  - Documentation is being assembled for review
- Talbert Medical Group dba Optum
  - Grant is closed
  - Documentation is being assembled for review

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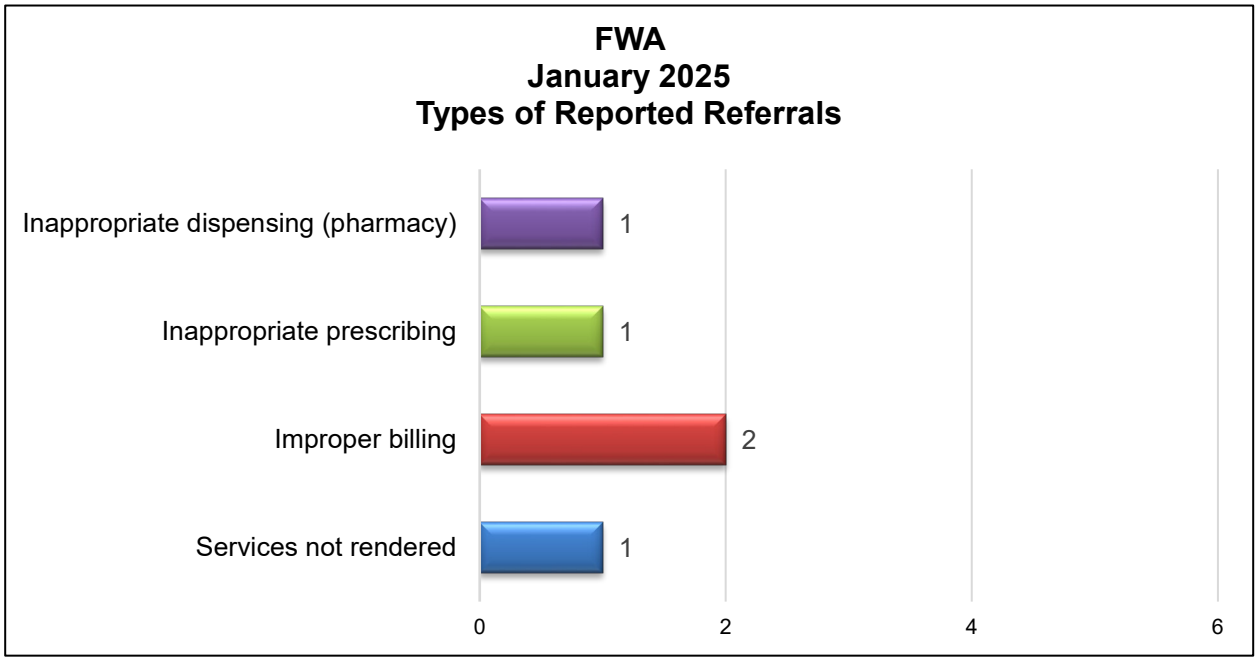
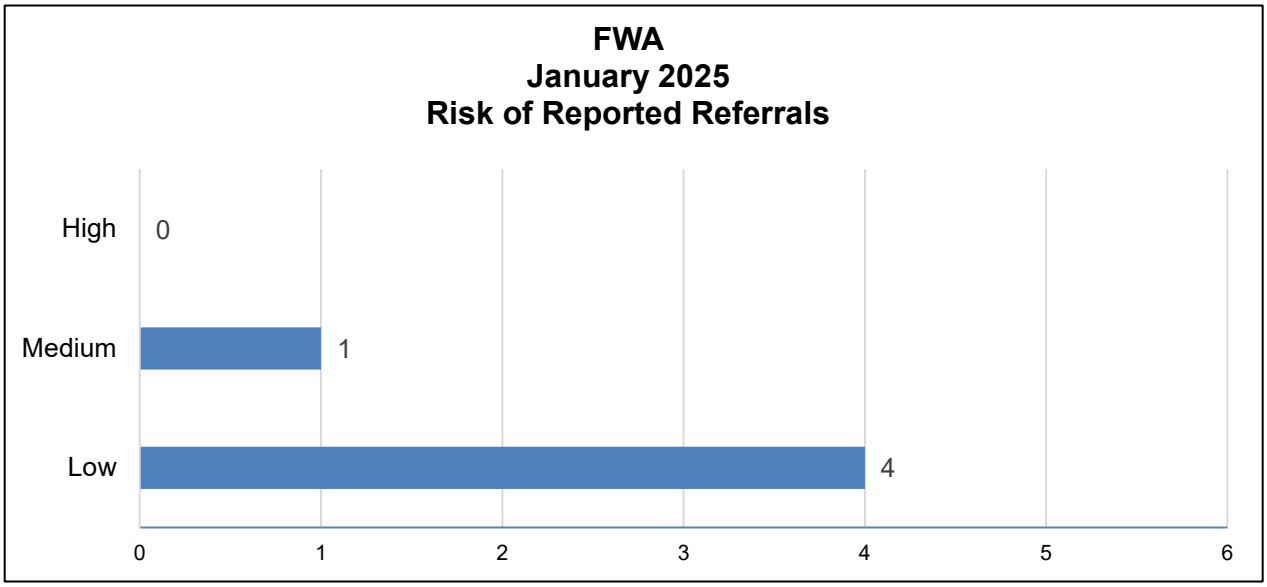
E. Fraud, Waste & Abuse (FWA) Investigations





Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS	4
Total Number of Referrals Reported	**5**

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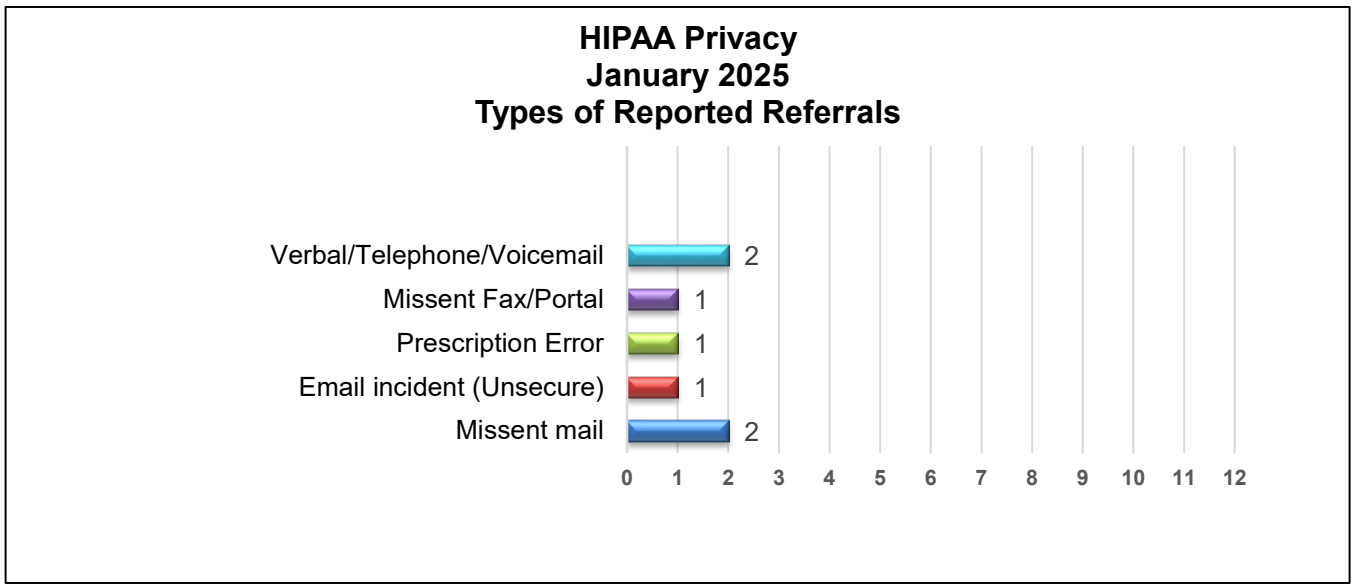
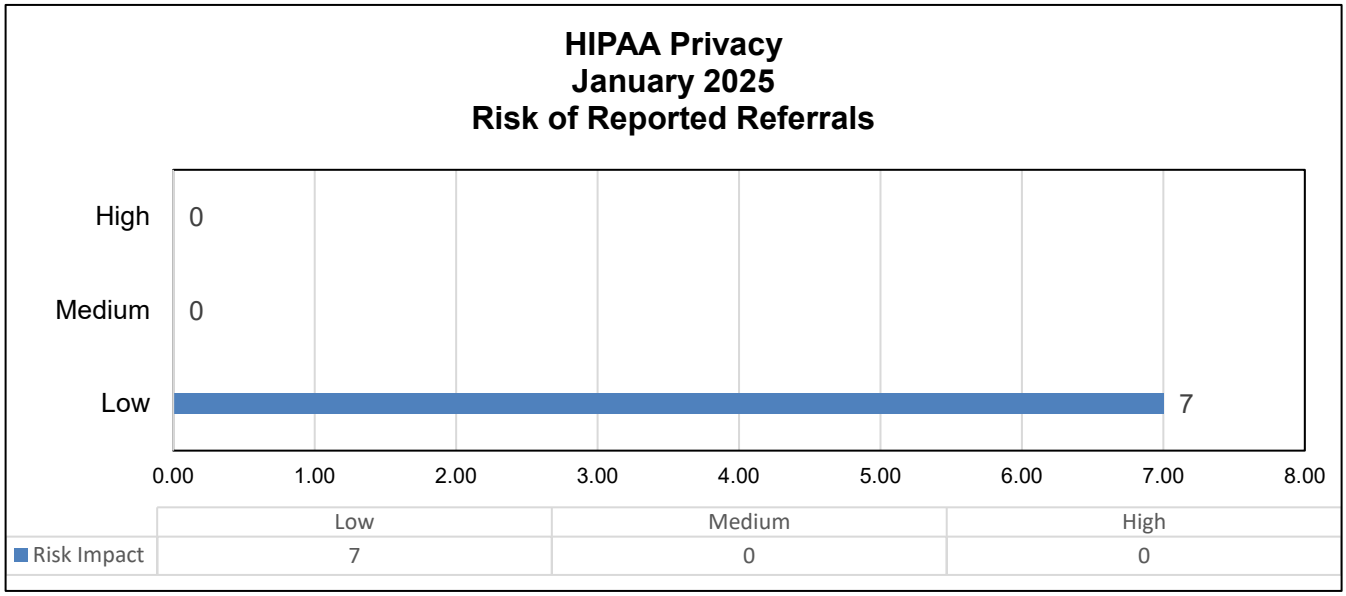
F. Privacy Update





Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: February 24, 2025

SUBJECT: Board of Directors Report – March 2025

CalOptima Health, Chamber Hill Strategies Advocate for Priorities in Budget Debate

CalOptima Health and Chamber Hill Strategies (CHS) continue to partner and maintain regular contact with congressional offices representing CalOptima Health's members and Orange County in Congress. In February, Jordan Abushawish, Senior Director, Federal and Local Government Affairs, and Donovan Higbee, Director, Public Policy, traveled to Washington, D.C., and CHS coordinated a series of Capitol Hill meetings to introduce CalOptima Health to new congressional staff and offices while also stressing the importance of ensuring support for CalOptima Health and its members in the context of the congressional budget process. Meetings included staff to the following offices: Senator Alex Padilla (D-CA), Senator Adam Schiff (D-CA), Representative Lou Correa (D-CA-46), Representative Young Kim (R-CA-40), Representative Derek Tran (D-CA-45), Representative Dave Min (D-CA-47), Representative Linda Sanchez (D-CA-38), and Representative Mike Levin (D-CA-49).

CalOptima Health, Chamber Hill Strategies Extend Advocacy Reach Beyond Orange County

With the pending budget debate in Congress, Chamber Hill Strategies (CHS) and CalOptima Health are working to raise the visibility of CalOptima Health, its unique programs, and stress the importance of supporting Medicaid and the work that CalOptima Health is doing to serve its members. Reaching beyond the Orange County delegation, CHS coordinated a series of strategic meetings for CalOptima Health to meet with congressional offices in leadership and those serving on key Committees with health policy jurisdiction. Meetings included the following California delegation offices: Representative Pete Aguilar (D-CA-33), Chair, House Democratic Caucus; Representative Jay Obernolte (R-CA-23), member, House Committee on Energy & Commerce, Subcommittee on Health; and Representative Nanette Barragan (D-CA-44), member, House Committee on Energy & Commerce, Subcommittee on Health. As Caucus Chair, Rep. Aguilar is the highest-ranking Californian in House leadership, and as members of Energy & Commerce Health Subcommittee, both Reps. Obernolte and Barragan serve on the key House subcommittee on Medicaid policy. Extending beyond California, CHS also coordinated a meeting with the office of Sen. Bill Cassidy, MD (R-LA) who serves as Chair of the Senate Committee on Health, Labor, & Pensions (HELP), and as a member

of Senate Committee on Finance; in these roles and as a physician, Sen. Cassidy is widely regarded as a leader in health policy issues and in Medicaid and Medicare as well.

CalOptima Health Hosts Orange County Delegation Members

In February, CalOptima Health and Chamber Hill Strategies partnered to schedule in-person meetings on behalf of CalOptima Health Chief Executive Officer Michael Hunn and other executive management team members with members of the Orange County delegation. On February 14, CalOptima Health hosted Representative Young Kim (R-CA-40) at headquarters where CalOptima Health CEO Michael Hunn, Chief Administrative Officer Veronica Carpenter, Chief Operating Officer Yunkyung Kim, and Senior Director of Federal and Local Government Affairs Jordan Abushawish met with Rep. Kim and discussed the importance of preserving support for Medicaid funding and flexibilities in the budget discussions in Congress. The following Friday, February 21, CalOptima Health hosted newly elected Representative Derek Tran (D-CA-45), introducing him to CalOptima Health and its programs while highlighting CalOptima Health's policy priorities as well. Future meetings are being planned with other Orange County delegation offices in the coming weeks.

Robert F. Kennedy, Jr. Confirmed as HHS Secretary, CMS Nominee Hearings Upcoming

In February, the United States Senate continued its fast-paced consideration and approval of President Trump's Cabinet-level and other high-ranking nominations. After January hearings, on February 4, the Senate Finance Committee advanced the nomination of Robert F. Kennedy, Jr. to be U.S. Secretary of Health & Human Services (HHS) in a 14-13 vote that broke down along party lines. The next week, on February 13, the full Senate voted to approve Kennedy's nomination in a 52-48 vote; later that same day, Kennedy was sworn in as the 26th HHS Secretary in U.S. history. To date, hearings have not yet been scheduled to hear testimony from Mehmet Oz, MD, the nominee to serve as Administrator of the Centers for Medicare & Medicaid Services (CMS). The nominee has been meeting with Senators regarding his nomination to head CMS, and a hearing at the Senate Finance Committee is expected to be scheduled soon.

Outlook for 2025 Government Funding Remains Unclear with March 14 Deadline Looming

As previously reported, in December, President Joe Biden signed legislation (H.R. 10545) into law to fund the government at Fiscal Year 2024 levels through March 14, 2025. The stopgap bill, known as a "continuing resolution" (CR), averted a government shutdown in December and was passed after a larger deal to fund the government fell apart. With the March 14 deadline approaching, congressional leaders need to reach a new agreement to fund the government for the remainder of Fiscal Year 2025 (FY25), which runs through September 30, 2025. As of this writing, House and Senate Appropriations Committee leaders had not yet reached an agreement on spending targets for FY25 funding, which is a first step toward a full funding deal. It is also expected that Congress would most likely use the funding legislation (the CR) to extend funding for certain health programs, but it could also move those items as part of a larger health legislative package. Other potential items that have been discussed for possible inclusion in FY25 government funding legislation are disaster relief for those impacted by the wildfires in southern California and provisions that would increase the debt ceiling, which sets a limit on the amount of debt the federal government is allowed to carry.

Senate and House Advance Competing Budget Proposals, Next Steps Unclear

Over the past two weeks, there has been considerable maneuvering between the House and Senate in the congressional budget process. After delays on the House side, Senate Budget Committee Chairman Lindsey

Graham (R-SC) scheduled his committee's consideration of a narrowly crafted budget resolution (S. Con. Res. 7) which would focus on spending items affecting defense, energy, immigration, and border security; and on February 12, the Senate Budget Committee advanced the measure. The Senate committee action put pressure on the House to act, and the following day, February 13, the House Budget Committee approved a much more expansive budget resolution (H. Con. Res. 14) before breaking for the President's Day week. Unlike the Senate budget resolution, the House resolution would include $1.4 trillion in spending cuts to go with $4.5 trillion in tax cuts and a $4 trillion increase in the federal debt limit. Notably, the House budget included $880 billion in savings for areas under the jurisdiction of the House Energy & Commerce Committee, which includes a wide range of programs including Medicaid and Medicare. While the resolution does not name Medicaid or Medicare for cuts, it is expected that should this number of $880 billion be in the final package, these instructions would likely lead to reductions in Medicaid and potentially Medicare. In contrast, the Senate budget resolution currently only calls for $1 billion in savings under the jurisdiction of the Senate Finance Committee, whose jurisdiction includes Medicaid and Medicare and other programs as well.

With the House being out of session for the week of February 17, Senate Majority Leader John Thune (R-SD) pushed forward with the Senate's budget resolution, and after a marathon session of amendments and debate, the Senate cleared its budget resolution early on the morning of February 21. A wrench was thrown in the process when President Trump announced his endorsement of the House bill, but Republican Senators moved forward undeterred, believing their approach, which would address larger issues like taxes and health care at a future date, provides the best opportunity for success in moving the President's agenda forward. As of this writing, the House was moving toward consideration of its budget resolution, targeting Tuesday, February 25 as the day for consideration on the House floor, but with several House Republicans expressing concern about potential Medicaid cuts, it is not clear if House Republican leaders will have the votes to pass the resolution. The back-and-forth between the chambers has the potential to draw out the budget process over the next several months.

President Issues Executive Order Limiting Federal Funds to Immigrants without Legal Status

On February 19, President Trump issued an executive order stating that immigrants without legal status are not eligible to receive federal benefits and that state and local governments cannot use federal funding to support policies that limit local law enforcement assistance and engagement with federal immigration officials. The order does not explicitly mention public charge, but it would be similar to public charge policy, which can be used to deny legal status to immigrants who are viewed as likely to require long-term federal assistance and resources. In addition, the policy could potentially be utilized to deny funding to organizations aiding immigrants without legal status. The full impact and application of the order will not be immediately realized but will likely play out over time. Furthermore, while not yet filed as of this writing, legal challenges, which could impact the order and its scope, are likely as well.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
February 24, 2025

General Update

The 2025 bill introduction deadline of February 21 created a flurry of activity, with over 500 bills introduced on deadline day. Even though new rules only allow 35 bills per legislator in a two-year legislative session, the 2,350 bills introduced this year demonstrate no slow-down of activity. Of the total bills introduced, 871 are "placeholder" bills which lack substantive language and often morph in unanticipated ways. These represent 37% of bills introduced, which is consistent with historical data.

As anticipated, the legislature passed and the Governor signed into law on February 9 two bills from the Special Session to "Trump-proof" the state. These bills allocate a total of $50 million to protect California's policies and residents from potential federal overreach. The legislation includes $25 million for the California Department of Justice to fund legal challenges against federal policies and another $25 million for legal aid organizations to defend immigrants facing deportation.

Legislative activity is picking up as budget and informational hearings get underway. With Los Angeles reeling from fires that destroyed more than 16,000 homes and structures, much discussion has focused on the need for housing. So, housing is again a hot topic of this legislative session.

The next legislative deadlines relate to passage of bills from their houses of origin: May 2 is the last day for policy committees to pass fiscal bills to fiscal committees; May 9 is the deadline for policy committees to pass nonfiscal bills; May 23 is the deadline for fiscal committees to pass fiscal bills; and June 6 is the last day to pass bills off the floor before heading to the other house.

Budget Update

The legislature's focus now shifts to the budget, which requires passage by June 15. Assembly and Senate budget subcommittee hearings are now underway. The budget is expected to remain in flux because of significant projected deficits and major federal uncertainty. It's also unclear if the Governor's $40 billion request to Congress for the Los Angeles wildfire recovery will be successful.

A bit of good news emerged from the independent Legislative Analyst's Office (LAO). Revenues are projected to be $4.4 billion above the Governor's budget projections for FY 2024-25 and $2.4 billion higher for FY 2025-26. The surge is believed to be linked to the strength of the stock market. The higher revenues are expected to improve the near-term bottom line of the state budget by a small net amount. This is because increased revenues over 40% must go to school spending or reserves.

PACE Proposed Changes - Two issues have arisen in the budget process related to PACE operations: 1) a budget change proposal (BCP) by DHCS for a fee assessment to fund 33 positions (about $6 million/year) to support the rapid expansion of PACE plans, and; 2) a budget trailer bill to allow sanctions to be levied against plans to achieve uniformity in sanctions across Medi-Cal programs.

The BCP for the fee assessment is raising questions among CalPACE members, and more information has been requested. Rapid PACE growth and the accompanying concern from DHCS seem to be a

result of venture capitalists entering the PACE market. It's unclear if the administration will ultimately approve the BCP in the current budget climate, yet there is further concern about the fallout without securing an approval (i.e., will DHCS limit approvals or stop PACE growth?). More information is forthcoming.

Early indications are that the trailer bill language regarding sanctions is not seen as problematic because the sanctions align with current Medi-Cal managed care plan rules.

Key Legislation Updates

SB 324: Community Provider Preference for Enhanced Care Management (ECM) Benefits – Senate Health Chair Caroline Menjivar-D (with President Pro Tem Mike McGuire-D as a Principal Co-author) introduced SB 324 on February 11. This bill requires a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to give preference to contracting with community providers, when they are available in the county and have the applicable ECM or community support experience.

Single-Payer Healthcare – The California Nurses Association has stepped back from its annual drive for single-payer healthcare after pushing the issue for two decades. Instead, the union, understanding the current political reality under a new federal administration, is focusing on educating legislators and rebuilding support for CalCare, a proposed state-run universal health care system.

Other Program Updates

Behavioral Health Transformation (BHT) (Proposition 1) – Round 1 (Launch Ready) grant funding for the Behavioral Health Continuum Infrastructure Program (BHCIP) is underway. DHCS will award up to $3.3 billion in grants in May 2025. Round 2 (Unmet Needs) solicitations are scheduled for release in May 2025.

The LAO released a Proposition 1 progress report earlier this month. While it highlighted that the program is building much needed infrastructure and the bulk of the dollars are benefiting Medi-Cal enrollees, there were several concerns identified, including:

- Align awards with needs – Only four out of ten regions with the most need have benefited. This raises concern that historical regional inequities are being reinforced.
- BHCIP not working in small counties – Funding has been concentrated in 11 out of the 30 small counties, with 19 receiving no funding.
- BHCIP not working well for all applicants – The scoring preference for launch-ready projects creates significant challenges, limiting success in siting the hardest-to-build facilities.

California Essential Health Benefits (EHB) – With potential changes to the Affordable Care Act looming, Senate and Assembly Health Committees held a joint hearing on February 11 to review possible additions to the EHBs, which have not changed since 2012. Proposed coverage expansion includes hearing aids, adult dental, and durable medical equipment. An application is expected to be submitted to CMS in May 2025, with an effective date of the new EHBs, if approved, in January 2027.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 476 Valladares	**Residential Therapeutic Programs:** States the intent of the Legislature to enact legislation relating to short-term residential therapeutic programs.	**02/20/2025** Introduced	CalOptima: Watch
SB 482 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant.	**02/20/2025** Introduced	CalOptima: Watch
AB 37 Elhawary	**Behavioral Health Workforce:** States the intent of the Legislature to enact legislation related to expanding the workforce of those who provide mental health services to persons experiencing homelessness.	**12/02/2024** Introduced	CalOptima: Watch
AB 348 Krell	**Full-Service Partnership:** Would establish presumptive eligibility for Full-Service Partnership programs.	**01/29/2025** Introduced	CalOptima: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care.	**02/04/2025** Introduced	CalOptima: Watch
AB 423 Davies	**Discharge and Continuing Care Planning:** Would mandate regulations for discharge and continuing care planning from a facility providing alcoholism or drug abuse recovery and treatment services, including the creation of a plan to help patients return to their home community and scheduled follow-up with a mental health or SUD professional no more than seven days after discharge.	**02/05/2025** Introduced	CalOptima: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan and Drug Medi-Cal program to electronically share data for its members of to support care. Would also require the California Department of Health Care Services (DHCS) to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027.	**02/12/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 669 Haney	**SUD Utilization Review:** Would prohibit the review of medical necessity for the first 28 days of inpatient SUD treatment and restrict retrospective review for the initial 28 days of intensive outpatient or partial hospitalization services. Would also prohibit prior authorization for outpatient prescription drugs treating SUDs deemed necessary by certain health care professionals.	**02/14/2025** Introduced	CalOptima: Watch
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027.	**02/20/2025** Introduced	CalOptima: Watch
AB 951 Ta	**Autism Diagnosis:** Would prohibit a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition.	**02/21/2025** Introduced	CalOptima: Watch
AB 1090 Davies	**Behavioral Health and Wellness Screenings:** States the intent of the Legislature to enact legislation relating to behavioral health and wellness screenings.	**02/21/2025** Introduced	CalOptima: Watch
Budget			
SB 65 Weiner	**Budget Act of 2025:** Would make appropriations for the government of the State of California for the 2025–26 fiscal year in alignment with the governor's proposed budget released on January 10, 2025.	**01/10/2025** Introduced	CalOptima: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers when covering the ECM benefit or community support. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. Finally, would require DHCS to annually update rate guidance as a benchmark for MCPs to use to reimburse for ECM and community supports.	**02/11/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 543 Wiener	**Street Medicine:** Would integrate street medicine services for homeless individuals under Medi-Cal, mandating presumptive eligibility for full Medi-Cal benefits for homeless persons and authorizing any enrolled provider to determine eligibility. Would also require plans to allow homeless beneficiaries to access services from any provider outside traditional sites. Additionally, would require systems for beneficiaries to inform plans of their homeless status and mandate data sharing between Medi-Cal and the California Statewide Automated Welfare System (CalSAWS).	**02/12/2025** Introduced	CalOptima: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Effective January 1, 2026, would prohibit a health plan from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Would also prohibit a health plan from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin.	**12/02/2024** Introduced	CalOptima: Watch
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** States the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.	**01/09/2025** Introduced	CalOptima: Watch
SB 466 Caballero	**Women's Health:** States the intent of the Legislature to enact legislation relating to women's health.	**02/20/2025** Introduced	CalOptima: Watch
SB 535 Richardson **AB 575** Arambula	**Obesity Prevention Treatment and Parity Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one anti-obesity medication and intensive behavioral therapy for the treatment of obesity without prior authorization.	**02/12/2025** Introduced	CalOptima: Watch
AB 54 Krell	**Access to Safe Abortion Care Act:** States the intent of the Legislature to enact legislation that would ensure access to medication abortion, such as mifepristone and misoprostol.	**12/02/2024** Introduced	CalOptima: Watch
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027.	**1/15/2025** Introduced	CalOptima: Watch
AB 260 Aguiar-Curry	**Reproductive Care Access:** States the intent of the Legislature to enact legislation ensuring patient access to care, including abortion, gender-affirming care, and other sexual and reproductive health care, and to allow patients to access care through asynchronous telehealth modalities.	**01/17/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account.	**01/23/2025** Introduced	CalOptima: Watch
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026.	**01/29/2025** Introduced	CalOptima: Watch
AB 360 Papan	**Menopause:** States the intent of the Legislature to enact legislation related to menopause.	**01/30/2025** Introduced	CalOptima: Watch
AB 432 Bauer-Kahan	**Menopause:** Would require a health plan to provide coverage for evaluation and treatment options for perimenopause and menopause. Would also require a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause.	**02/05/2025** Introduced	CalOptima: Watch
AB 602 Haney	**Antiretroviral Drugs:** Would require a health plan to cover specified antiretroviral drugs, including preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) without cost-sharing or utilization review requirements.	**02/13/2025** Introduced	CalOptima: Watch
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards	**02/13/2025** Introduced	CalOptima: Watch
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver.	**01/23/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 974 Patterson	**Managed Care Enrollment Exemption:** States the intent of the Legislature to enact legislation that would exempt from mandatory enrollment in a Medi-Cal MCP any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage.	**02/21/2025** Introduced	CalOptima: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals.	**02/21/2025** Introduced	CalOptima: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services, to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to a beneficiary who has been displaced or otherwise affected by a state of emergency or a health emergency for at least 90 days after declaration or at least the entire duration of the emergency, whichever is longer.	**02/21/2025** Introduced	CalOptima: Watch
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Would permit additional disclosures to DHCS staff and Medi-Cal MCPs to improve care coordination and quality programs for HIV-positive beneficiaries. Would also update existing laws to enhance quality improvement efforts in HIV care under Medi-Cal.	**02/04/2025** Introduced	CalOptima: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Would prohibit a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Would also prohibit these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena.	**02/20/2025** Introduced	CalOptima: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Would extend current Medi-Cal time and distance standards indefinitely. In addition, would require a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS. Additionally, the use of telehealth providers to meet time or distance standards would not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers.	**02/21/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 40 Bonta	**Abortion as Emergency Service:** Would expand the definition of emergency services to include reproductive health services, including abortion.	**12/02/2024** Introduced	CalOptima: Watch
AB 45 Bauer-Kahan	**Reproductive Privacy Data:** States the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services. Would also prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request, if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act.	**12/02/2024** Introduced	CalOptima: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers.	**01/16/2025** Introduced	CalOptima: Watch
AB 302 Bauer-Kahan	**Confidentiality of Medical Information Act:** Would prohibit a health care provider, health plan or contractor from disclosing medical information in response to another state's court order based on a law in that state which interferes with California law. Would also prohibit such entities from disclosing medical information based solely on patient authorization.	**01/23/2025** Introduced	CalOptima: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027.	**02/04/2025** Introduced	CalOptima: Watch
AB 577 Wilson	**Antisteering:** Would prohibit a health plan or pharmacy benefit manager from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions, or exclusions that discriminate against a physician in connection with dispensing prescription oral medications.	**02/12/2025** Introduced	CalOptima: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, would require DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report.	**02/14/2025** Introduced	CalOptima: Watch
AB 894 Carrillo	**Immigration and Patient Privacy:** Would state the intent of the Legislature to enact legislation protecting the privacy of undocumented Californians	**02/20/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard.	**02/21/2025** Introduced	CalOptima: Watch
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition.	**01/30/2025** Introduced	CalOptima: Watch
SB 412 Limón	**Home Care Aides:** Would require a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter.	**02/14/2025** Introduced	CalOptima: Watch
AB 346 Nguyen	**In-Home Supportive Services (IHSS) Certification:** Expands the definition of a "licensed health care professional" who is allowed to certify IHSS eligibility to include any person who is a health care practitioner under the Business and Provisions Code. Would also clarify that, as a condition of receiving paramedical services, an applicant or recipient is required to obtain a certification from a licensed health care professional, as specified.	**01/29/2025** Introduced	CalOptima: Watch
AB 960 Garcia	**Dementia Patient Visitation:** Would require a health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed.	**02/21/2025** Introduced	CalOptima: Watch
Providers			
SB 32 Weber	**Maternity Ward Closures:** States the intent of the Legislature to enact legislation to address maternity ward closures.	1**2/02/2024** Introduced	CalOptima: Watch
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Would require a provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type.	**01/30/2025** Introduced	CalOptima: Watch
SB 306 Becker	**Prior Authorization Gold Carding:** Would restrict health plans from requiring prior authorization for a covered health care service if certain conditions are met, such as approving 90% or more requests in the previous year. If a service qualifies for this exemption, it must be listed on the provider's website by March 15 annually.	**02/10/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 504 Laird	**HIV Reporting:** Would authorize a health care provider of a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH.	**02/20/2025** Introduced	CalOptima: Watch
SB 626 Smallwood-Cuevas	**Maternal Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition.	**02/21/2025** Introduced	CalOptima: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings under Medi-Cal.	**12/02/2024** Introduced	CalOptima: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Would allow pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements would become limited to prescription-only hormonal contraceptives.	**12/02/2024** Introduced	CalOptima: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Would remove the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement.	**12/02/2024** Introduced	CalOptima: Watch
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would mandate health facilities providing pediatric or adult subacute care to include a specific DHCS form with treatment authorization requests, preventing Medi-Cal MCPs from creating their own criteria for determining medical necessity outside of those specified in the form. Would allow DHCS to impose sanctions on non-compliant Medi-Cal MCPs.	**01/08/2025** Introduced	CalOptima: Watch
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to create a standardized format to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026.	**01/21/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional.	**02/04/2025** Introduced	CalOptima: Watch
AB 416 Krell	**Involuntary Commitment:** Would authorize a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and would exempt the emergency physician from criminal and civil liability.	**02/05/2025** Introduced	CalOptima: Watch
AB 510 Addis	**Utilization Review Appeals and Grievances:** Would require that an appeal or grievance regarding a decision to delay, deny or modify health services be reviewed by a physician matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved.	**02/10/2025** Introduced	CalOptima: Watch
AB 512 Harabedian	**Prior Authorization Timelines:** Would shorten the timeline for prior authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination.	**02/10/2025** Introduced	CalOptima: Watch
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair.	**02/10/2025** Introduced	CalOptima: Watch
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval.	**02/11/2025** Introduced	CalOptima: Watch
AB 1041 Bennett	**Provider Credentialing:** Would require a health plan to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan would be required to notify the provider whether the application is complete within 10 days of receipt. In addition, would require DMHC to establish minimum standards or policies and processes to streamline and reduce redundancy and delay in provider credentialing. Additionally, would require health plans to use a standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later, with updates to the forms every three years thereafter.	**02/21/2025** Introduced	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
SB 246 Grove	**Medi-Cal Graduate Medical Education (GME) Payments:** Would require DHCS to provide additional GME payments to district and municipal public hospitals (DMPHs) using voluntary intergovernmental transfers (IGTs) from the DMPHs or other eligible public entities. Would also create a new special fund for such purposes.	**01/30/2025** Introduced	CalOptima: Watch
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would allow Medi-Cal reimbursement rates to clinical laboratory or laboratory services for the diagnosis and treatment of sexually transmitted infections to exceed the average lowest rate of other payers and other state Medicaid programs for similar services.	**02/12/2025** Introduced	CalOptima: Watch
Social Determinants of Health			
SB 16 Blakespear	**Homelessness:** States the intent of the Legislature to enact legislation to address homelessness.	**12/02/2024** Introduced	CalOptima: Watch

Information in this document is subject to change as bills proceed through the legislative process.

Last Updated: February 21, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

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

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

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

CalOptima Health Community Outreach Summary — February and March 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria is met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

On Saturday, February 1, 2025, the Orange County Heritage Council celebrated 45 years of their annual Black History Parade & Unity Festival in downtown Anaheim. This long-standing event serves as a vibrant celebration of culture, unity and community engagement. CalOptima Health has been a proud supporter of this event for the past 10 years, demonstrating our ongoing commitment to supporting the health and well-being of our African American Orange County community.

This year, CalOptima Health had a strong presence, hosting eight booths representing multiple departments, including PACE, Community Relations, Customer Service, Equity and Community Health, OneCare and Black Infant Health Programs & Doula Services. These teams provided valuable health services such as dietitian consultations, smoking cessation resources, nutrition education and Medi-Cal information.

CalOptima Health collaborated with Serve the People to further expand access to care by offering on-site medical, dental and vision services to attendees. This partnership ensured that community members had direct access to essential health screenings and consultations.

Additionally, the event provided an important opportunity to increase awareness of the Medi-Cal Expansion. CalOptima Health's participation reaffirmed our mission to bridge health care gaps and support the diverse needs in our local community.

Summary of Public Activities

As of February 3, CalOptima Health plans to participate in, organize or convene 69 public activities in February and March. There were 34 public activities in February, including 15 virtual community/collaborative meetings, 14 community events, three community-based presentations, one Cafecito Meeting and one Health Network

Forum. In March, there will be 35 public activities, including 16 virtual community/collaborative meetings, 14 community events, four community-based presentations and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided three endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for the Multi-Ethnic Collaborative of Community Agencies' (MECCA) application for HIV/STI Prevention and Treatment Services, Projects 3 and 4.

2. Letter of support for Alianza Translatinx's application for HIV/STI Prevention and Treatment Services.

3. Letter of support for Community Action Partnership of Orange County's (CAP OC) application for their Empowered2Work and Healthy Homes Apprenticeship program.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the March 6, 2025 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in February and March 2025:

February 2025

February 1–2, 11 a.m.–7 p.m., Tết Festival, hosted by The Union of Vietnamese Students Association

Garden Grove Park, 9301Westminster Blvd., Garden Grove

- Sponsorship fee: $15,000; included a resource booth, logo on all posters, flyers and website for one year, three banners displayed throughout the event, 60 admission tickets, six VIP admissions and six VIP parking permits, an honorary plaque from Tết Festival Board of Directors, half page color ad in magazine, speech at Opening Ceremony, five mentions on stage and 30 radio impressions
- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public

February 1, 9 a.m.–4 p.m., Black History Parade and Unity Festival, hosted by the Orange County Heritage Council

Anaheim Promenade, 205 W. Center St. Promenade, Anaheim

- Sponsorship fee: $25,000; included website and social media recognition, Unity Festival stage recognition, full-page advertisement in the event's souvenir book, eight resource booths at the event, three banner displays, 10 VIP badges, two cars in the parade featuring CalOptima Health's logo and CalOptima Health's logo printed on event T-shirts
- At least 10 staff members attended (in person)
- Health/Resource Fair, open to the public

February 6, 3–6 p.m., OC Equity Profile, hosted by OC Grantmakers

The Cove at UCI, 5270 California Ave. #100, Irvine

- Sponsorship fee: $1,000; included four tickets to attend event, logo recognition at the event and logo recognition on OC Grantmaker's equity profile website
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 6, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anna Drive Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

February 6, 6:20–8 p.m., Open House, hosted by La Vista-La Sierra High School

La Vista High School, 909 N. State College Blvd., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 8, 4–6 p.m., Love Shouldn't Hurt Teen Conference, hosted by Human Options

Santa Ana High School, 520 W. Walnut St., Santa Ana

- Sponsorship fee: $5,000; included a resource table and logo on flyer
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 11, 8:30–10:30 a.m., 211 Day, hosted by Orange County United Way

Norma Hertzog Community Center, 1845 Park Ave., Costa Mesa

- Sponsorship fee: $5,000; included a resource table, recognition on the event invitation and email communications, and recognition on event materials
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 14, 10–11:30 a.m., CalOptima Health Medi-Cal Overview in English

Linbrook Court, 2240 W. Lincoln Ave., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

February 20, 4–6 p.m., Health Care Forecast Conference, hosted by the University of California Irvine

Beckman Center, 100 Academy Way, Irvine

- Sponsorship fee: $5,000; included a marketing tool kit for social media posts and visibility, a display table with CalOptima Health information, social media announcement featuring sponsors, company logo recognition in pre-conference emails, company logo on all marketing materials, conference and website and complimentary conference registration for two guests
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 20, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Acacia Romneya Drive Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 21, 10:30 a.m.–2:30 p.m., Recovery Art Event, hosted by Pacific Clinics Recovery Education Institute

Recovery Education Institute, 401 S. Tustin St., Orange

- Sponsorship fee: $500; included a resource table, program acknowledgment, and featured in all media for the event
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

February 21, 2–6 p.m., We Care Wellness and Education Fair, hosted by Santa Ana Unified School District

Saddleback High School, 2802 S. Flower St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 22, 4–6 p.m., Mental Health Summit, hosted by Big Brothers, Big Sisters of Orange County

Samueli Academy, 1901 N. Fairview St., Santa Ana

- Sponsorship fee: $2,500; included recognition of sponsorship during opening remarks and resource booth at the event
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 25, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health

Virtual

- At least four staff members attended
- Steering committee meeting, open to collaborative members

February 26, 11 a.m.–12:30 p.m., CalOptima Health Medi-Cal Overview in English

MJ Housing Services, 105 Avenida Presidio, San Clemente

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

February 26, 4–6 p.m., UCI Mental Health Fair, hosted by Partners4Wellness

University of California Irvine, 311 W. Peltason Dr., Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

February 27, 8:45–9:45 a.m., CalOptima Health Medi-Cal Overview in Spanish

Madison Elementary School, 1124 Hobart St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

February 27, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Laxore Embassy Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 2025

March 1, 9 a.m.–1 p.m., Community Resource Fair, hosted by CalOptima Health and the City of Laguna Niguel

Crown Valley Community Center, 29751 Crown Valley Pkwy., Laguna Niguel

- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public

March 1, 9 a.m.–1 p.m., Community Resource Fun Fair, hosted by Garden Grove Unified School District

Santiago High School, 12342 Trask Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 1, 10 a.m.–3 p.m., Veterans Stand Down, hosted by the National Veterans Service

Garden Grove Elks Lodge, 11551 Trask Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 2, 12–6 p.m., Annual Ethiopian Day, hosted by Ethio-American Generational Bridge

Craig Regional Park, 3300 S. State College Blvd., Fullerton

- Sponsorship fee: $500; included a resource table, half-page ad, and feature in the program
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 4, 8–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Olive Street Elementary School, 890 S. Olive St., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 6, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Esqueda Elementary School, 2240 S. Main St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 6, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Balsam Curtis Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

March 7, 8–9:30 a.m., CalOptima Health Medi-Cal Overview in English
Olive Street Elementary School, 890 S. Olive St., Anaheim

- At least one staff member to present (in person)
- Community-based organization presentation, open to members/community

March 7, 11 a.m.–1 p.m., Golden Futures Expo, hosted by Golden Futures Expo
Hyatt Regency Newport Beach, 1107 Jamboree Rd., Newport Beach

- Sponsorship fee: $595; includes a resource booth, organization's name and profile in expo guide, organization hyperlink on website and promotional item in swag bag
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 8, 11 a.m.–1 p.m., Deaf/Hard of Hearing Resource Fair, hosted by Regional Center of Orange County
Anaheim Central Public Library, 500 Broadway Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 8, 7:30 a.m.–1 p.m., Social Drivers Conference, hosted by the American Academy of Pediatrics
UCI Sue Gross Auditorium, 854 Health Sciences Rd., Irvine

- Sponsorship fee: $1,000; includes a resource booth
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Ventura Greenacre Moraga Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 19, 5–7 p.m., Back to School Night and Open House, hosted by Centralia Elementary School
Centralia Elementary School, 195 N. Western Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 21, 8:45–9:45 a.m., CalOptima Health Medi-Cal Overview in Spanish
Lowell Elementary School, 700 Flower St., Santa Ana

- At least one staff member to present (in person)
- Community-based organization presentation, open to members/community

March 26, 8 a.m.–4 p.m., 2025 Spirituality Conference, hosted by Hoag Hospital
Fullerton Free Church, 2801 N. Brea Blvd., Fullerton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

March 26, 8 a.m.–12 p.m., Kids Fishing Derby, hosted by the Office of Orange County Supervisor Doug Chaffee

Ralph B. Clark Regional Park, 8800 Rosecrans Ave., Buena Park

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 27, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Ventura Greenacre Moraga Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

March 30, 4–6 p.m., Health and Wellness Fair, hosted by the City of Fullerton

Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- Registration fee: $100; includes a resource table
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

Board-Approved Strategic Initiatives Executive Summary – Report Period: October 2024-December 2024

CalOptima Health's Board of Directors has authorized $1,425.2 million in funding and investment in programs and strategic initiatives to improve community and member health and wellness. Detailed impact summary reports are attached.

Exhibit 1: Board Approved Initiatives (as of December 31, 2024)

Board-approved Initiatives	INITIATIVE LEADER	Program Status	Payment Status	Board Approved Amount	Spent Amount	Additional Amounts Committed	Resource Available[2]	Duration
Community Outreach and Investments								
Adult Expansion Outreach Strategy	Thompson	In progress	In Progress	$ 7.6	$ 3.4	$ 3.2	$ 0.9	CY 2024
CalFresh and Redetermination Outreach	Thompson	In progress	In Progress	$ 6.0	$ 4.0	$ (0.0)	$ 2.0	Ongoing
CalFresh Outreach Strategy	Thompson	In progress	In Progress	$ 2.0	$ 2.0	$ (0.0)	$ 0.0	Ongoing
CalOptima Health Community Reinvestment Program	Rose	Not yet started	Not yet started	$ 38.0	$ -	$ -	$ 38.0	CY 2024
Coalition of OC Community Health Centers	Laverdiere	In progress	In Progress	$ 50.0	$ 30.0	$ 20.0	$ -	FY 2023 - FY 2027
Community Living Project (Tustin Location)	Bruno-Nelson	In progress	In Progress	$ 18.0	$ 0.4	$ 0.1	$ 17.5	FY 2024 - TBD
Garden Grove Recovery Center Development and Maintenance	Bruno-Nelson	In progress	In Progress	$ 10.5	$ 0.5	$ -	$ 10.0	FY 2024
General Awareness and Brand Development	Thompson	In progress	In Progress	$ 4.7	$ 3.4	$ 0.9	$ 0.3	Ongoing
Homeless Health Initiative	Bruno-Nelson	In progress	In Progress	$ 61.7	$ 45.4	$ 13.2	$ 3.1	Multiple
Housing and Homelessness Incentive Program	Bruno-Nelson	In progress	In Progress	$ 87.4	$ 65.2	$ 21.7	$ 0.5	Multiple
In-Home Care Pilot Program	Dabbah	In progress	Not yet started	$ 2.0	$ -	$ -	$ 2.0	09/01/2023 - 08/31/2025
Member and Population Health Needs Assessment	Laverdiere	In progress	In Progress	$ 1.3	$ 0.2	$ 1.0	$ 0.0	FY 2024 - FY 2025
Mind OC Grant (Irvine)	Laverdiere	In progress	Complete	$ 15.0	$ 15.0	$ -	$ -	One-time (CY 2023 - CY 2024)
Mind OC Grant (Orange)	Laverdiere	Complete	Complete	$ 1.0	$ 1.0	$ -	$ -	One-time (FY 2022 - FY 2024)
Naloxone Distribution Event	Carpenter	In progress	In Progress	$ 15.0	$ 12.7	$ 0.2	$ 2.0	FY 2024
NAMI Orange County Peer Support Program	Katsarov	In progress	In Progress	$ 5.0	$ 1.5	$ 3.5	$ -	CY 2023 - CY 2027
OneCare Outreach and Engagement Strategy	Thompson	In progress	In Progress	$ 1.0	$ 0.4	$ 0.5	$ 0.0	04/01/2024 - 06/30/2024
Provider Workforce Development	Laverdiere	In progress	In Progress	$ 50.0	$ 4.4	$ 25.4	$ 20.3	FY 2024 - FY 2028
Stipend Program for Masters of Social Work	Laverdiere	In progress	Complete	$ 5.0	$ 5.0	$ -	$ -	FY 2024 - FY 2028
Wellness Prevention Program	Katsarov	In progress	In Progress	$ 2.7	$ 0.6	$ 2.1	$ -	FY 2024 - FY 2027
Subtotal				***$ 390.1***	***$ 198.3***	***$ 92.1***	***$ 99.6***	
Quality Incentive Programs								
Comprehensive Community Cancer Screening*	Pitts	In progress	In Progress	$ 50.1	$ 5.7	$ 12.9	$ 31.4	CY 2023 - CY 2027
Dyadic Services Program Academy	Katsarov	In progress	In Progress	$ 1.9	$ 0.9	$ -	$ 1.0	04/30/2024 - 03/31/2026
Five-Year Hospital Quality Program	Lee	In progress	In Progress	$ 153.5	$ 25.0	$ 128.5	$ -	CY 2023 - CY 2027
OneCare Member Health Incentives	Lee	Complete	In Progress	$ 0.5	$ 0.3	$ -	$ 0.2	01/01/2023 - 06/30/2023
Quality Initiatives from Unearned P4V Program	Lee	In progress	In Progress	$ 23.3	$ 1.9	$ 0.7	$ 20.7	FY 2024 - FY 2025
Subtotal				***$ 274.0***	***$ 69.9***	***$ 142.1***	***$ 62.0***	
Infrastructure and Capacity Building								
Digital Transformation Strategy (DTS)[3]	Kim	In progress	In Progress	$ 100.0	$ 54.2	$ 14.9	$ 30.9	FY 2023 - FY 2025
Medi-Cal Provider Rate Increases	Gomez	In progress	In progress	$ 526.2	$ 105.2	$ 421.0	$ -	07/01/2024 - 12/31/2026
Skilled Nursing Facility Access Program	Dabbah	In progress	Not yet started	$ 10.0	$ -	$ -	$ 10.0	FY 2024 - FY 2026
Subtotal				***$ 761.2***	***$ 274.1***	***$ 443.6***	***$ 43.6***	
Total				**$ 1,425.2**	**$ 542.2**	**$ 677.8**	**$ 205.2**	

[1] Amounts Committed include payments and remaining balance of open Purchase Orders and/or an estimation of amounts committed

[2] Resource Available is the amount available for new initiatives after deduction of the Spent Amount and the Additional Amounts Committed from the Board Approved Amount

[3] Additional Amounts Committed for DTS are preliminary estimates

* Initiatives funded by IGT dollars

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	Adult Expansion Outreach Strategy	**Start Date:**	7/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2025
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$7.6 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health will implement the Adult Expansion Outreach Strategy to promote awareness and enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status, and enrollment in other public assistance programs (i.e., CalFresh).	Added more traditional media outlets, including OCTA buses (interior bus cards), laundromats, medical clinics and food trucks. CalOptima Health hosted 6 large-scale community events and included Community Enrollers to support Medi-Cal renewals and Medi-Cal and CalFresh enrollment assistance. Funded 12 community organizations to provide Community Enrollers for Medi-Cal renewal assistance and Medi-Cal and CalFresh enrollment assistance. $240,000 Medi-Cal expansion sponsorships to support 14 community events hosted by community-based organizations that included Community Enrollers.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a multimedia campaign in Spanish	Number of impressions/media buys	Impressions by media type for Q2: Digital advertising: 9,061,137 impressions Traditional advertising: 19,409,026 impressions
Conduct community outreach and enrollment events	Number of events hosted	CalOptima Health hosted 6 large-scale community events and included Community Enrollers to support Medi-Cal renewals and Medi-Cal and CalFresh enrollment assistance. These events served approximately 4,143 members and community members.
Increase awareness and enrollment in the Medi-Cal and CalFresh programs, with a focus on outreach to the undocumented population	Number of Community Enrollers	CalOptima Health funded 12 organizations for Community Enrollers to provide Medi-Cal renewal support and Medi-Cal and CalFresh enrollment assistance. CalOptima Health also provided $240,000 in Medi-Cal expansion sponsorships to support 14 community events hosted by community based organizations.
Create a communications toolkit to promote Medi-Cal expansion	Completion of communications toolkit	Toolkit materials posted online at www.caloptima.org/CoverageForAll; materials for community partners will be printed and shipped.
CalOptima Health Mobile Unit	Mobile unit purchased by end of 2024	CalOptima Health is working with our contracting department to release funding to purchase two CalOptima Health mobile units.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/11/2025	**Initiative Name:**	CalFresh and Redetermination Outreach	**Start Date:**	2/2/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$6.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health Outreach Strategy to support Medi-Cal redetermination and enroll potentially eligible CalOptima Health members in the CalFresh program.	CalOptima Health hosted 6 community events that supported Medi-Cal renewals and Medi-Cal and CalFresh enrollment assistance. The CalFresh advertising campaign was highly successful, garnering nearly 220 million impressions.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote Medi-Cal redetermination.	Campaign development Number of impressions/media buys	Advertising campaign launched October 2023 and ran through June 2024 in digital, print, radio, television and out-of-home. The campaign garnered nearly 220 million impressions.
Collaborate w/ key stakeholders by hosting community events focused on Medi-Cal redetermination and the CalFresh program throughout the county.	Number of community events Number of members served	Hosted 6 large-scale community events that included Medi-Cal renewals and Medi-Cal and CalFresh enrollment assistance. These events served approximately 4,143 members and community members. CalOptima Heath also hosted 6 CalFresh events at the Outlets of Orange in October through December.
Fund Community Enrollers to support members with Medi-Cal renewals and enrollment in CalFresh.	Number of Community Enrollers	Three community Enrollers were funded: -Two organizations provided services from June 1, 2023 thru May 31, 2024 -One organization provided services from February 1, 2024 thru May 31, 2024.
Community Enrollers to ensure as many members enroll/retain Medi-Cal coverage throughout the resumption of redetermination.	Number of completed membership enrollment and renewal applications	Community Enrollers completed 1,767 Medi-Cal renewal applications
Community Enrollers to engage members in the communty to provide Medi-Cal renewal assistance and CalFresh enrollment service	Number of community events	Community Enrollers attended 162 community events and hosted 30 community events. Additionally, the Community Enrollers shared 449 communications educating the community about Medi-Cal renewals.

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CalOptima Health

Community Investment Status Report
Initiative: Community Enrollers

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Abrazar, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 200,000	$ 100,000	In Progress
Camino Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 250,000	$ 125,000	In Progress
Community Action Partnership of OC (CAPOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 365,000	$ 182,500	In Progress
Give for a Smile	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 233,628	$ 116,814	In Progress
Orange County United Way	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 354,408	$ 177,204	In Progress
Serve the People Community Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 383,020	$ 191,510	In Progress
Vista Community Clinic	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 207,430	$ 103,715	In Progress
Community Health Initiative of OC (CHIOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500,000	$ 250,000	In Progress
Friends of Family Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 230.246	$ 115,123	In Progress
Latino Health Access	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
Mental Health Association of Orange County	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 349.593	$ 174,796.50	In Progress
Southland Integrated Services, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
					$	$	
					$	$	
					$	$	
					$	$	

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	CalFresh Outreach Strategy	**Start Date:**	3/3/20222
Reporting Period:	Oct-Dec (Q2)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$2.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalFresh Outreach Strategy is designed to enroll potentially eligible CalOptima Health members in the CalFresh program to promote food security.	County of Orange Social Services Agency reports a significant growth in CalFresh during the past three years based on our outreach strategy. The program has grown from a start of 258,133 enrolled in March 2022 to 322,170 enrolled as of August 2024, the most recent figure available.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote enrollment in CalFresh.	Campaign development Number of impressions/media buys	CalOptima Health spent $239,135 on campaign development. We anticipate garnering more than 400 million impressions on a total media placement budget of $1,190,200 (April 2022 to December 2024). In Q2 of FY 25, CalOptima Health began discussions about how to extend the campaign.
Collaborate w/ key stakeholders by hosting community events focused on the CalFresh program throughout the county.	Number of community events Number of members served	Hosted 6 large-scale community events that included Medi-Cal renewals and Medi-Cal and CalFresh enrollment assistance. These events served approximately 4,143 members and community members. CalOptima Heath also hosted 6 CalFresh events at the Outlets of Orange in October through December.
Produce direct mail promoting the availability of CalFresh benefits.	Number of mailers sent	In 2022, CalOptima Health sent direct mail to approximately 316,000 members, at a total cost of about $200,000. CalOptima Health and SSA are initiating a new process to identify CalOptima Health members who are not enrolled in CalFresh but are likely to qualify for a campaign in mid-2025.
Increase enrollment in CalFresh program.	Number of members supported by CalFresh	As of Q2 of FY 25, there has been an increase in the overall enrollment of more than 64,000 CalFresh recipients.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	CalOptima Health Community Reinvestment Program	**Start Date:**	11/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2026
Program Status:	Not Started	**Initiative Owner:**	Dr. Michaell Rose	**Approved Amount:**	$38.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Beginning with CY 2024, DHCS is requiring all MCPs to reinvest a portion of their net income in their local communities through community reinvestment activities as follows: - 5% of the portion of annual net income that is less than or equal to 7.5% of revenue for the year; and - 7.5% of the portion of annual net income that is greater than 7.5% of revenue for the year.	- BOD approved an initial commitment of up to $38 million to fund the Community Reinvestment (CR) Program on 10/5/2023. - DHCS distributed final All Plan Letter (APL) 25-004 CR Requirements on 2/7/25. - CalOptima Health is beginning the initial planning stages of setting up the Community Reinvestment Program per final DHCS guidance.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Establish Community Reinvestment Program governance	Governance established by Q1 2025, with implementation to begin Q2 2025	Governance will convene in Q1 2025.
Develop Community Reinvestment Program activities and workplan	Workplan developed by Q2 2025	Workplan in development. The Community Reinvestment Plan will be informed by the Member and Population Health Needs Assessment project. The initial Community Reinvestment Plan is due to DHCS in Q3 CY 2026.
Engage Community Stakeholders and Quality Improvement and Health Equity Committees	Stakeholder committees convened and number of listening sessions conducted for community input on investments	Not yet started
Allocate required portion of net income in improving the health and wellbeing of members through locally driven innovations and whole-person approach	% of annual net income reinvested in local communities	Not yet started
	Number of community reinvestment programs implemented	Not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/7/2025	**Initiative Name:**	Coalition of OC Community Health Centers	**Start Date:**	6/1/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2027
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Coalition's five-year, $50 million initiative with participating subgrantee community health centers to enhance access, quality, and further strengthen the safety net system across Orange County. The initiative focuses on building capabilities of participating clinics related to data and quality improvement, care delivery, and transitions towards value-based care.	- Year 3 SOW and ubdget plan submitted 10/2024, currently under review for CalOptima Health; Year 3 payment disbursement pending approval of SOW and budget plan. - OC Coaltion is working to design subset cohort of clinics to receive enhanced support for focus on enhancing value-based care capacity and capabilities. - Ongoing engagement by CalOptima Health to monitor progress of grant program and provide recommendations for alignment with strategic goals if necessary.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Provide monitoring, guidance, and support to subgrantee implementation projects from Year 1 to Year 3	% of planned milestones that have been successfully achieved within the specified timeframe	97% completed: Implemented project status reporting on a quarterly basis for participating health centers; Developed monitoring plans for health centers needing higher levels of technical assistance, which includes frequent oversight and targeted support.
Provide timely technical assistance and support to subgrantees over 5 year grant period	Number of training workshops, webinars, and sessions conducted	60% completed: Technical Assistance Team (IHQC) developed 2025 training schedule that includes, bi-monthly peer group meetings for clinics, trainings focused on data and quality improvement, and webinars on VBC topics such as empanelment.
Ensure data collection and reporting compliance over 5 year grant period	Timely submission of reports by health centers with feedback from technical assistance staff	60% completed: Standardized quarterly project status reports and project dashboards include tailored feedback loop from IHQC Team to help identify and address data quality issues.
Build the capacity of Coalition to support health centers in practice transformation and quality improvement from Years 2 to Year 5	-Positions outlined in the budget hired -% of Coalition staff completed technical assistance trainings	50% completed: Coalition staff members are actively participating in IHQC's training programs and undergoing training in Patient-Centered Medical Home to assist health centers. Plans for Coalition staff to shadow IHQC staff as they deliver technical assistance, to further develop Coalition staff's capacity.
Support health center staff in development of value-based quality improvement and data strategic plans	Creation of health center VBC strategic plans	50% completed: Coalition partnered with Curis Consulting to conduct strategic planning sessions with five of the participating health centers to focus on quality improvement and data analytics. Development of strategic plans will be expanded to remaining health centers.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/14/2025	**Initiative Name:**	Community Living Project	**Start Date:**	2/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$18.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Community Living Center will co-locate a recuperative care and PACE program designed specifically for unhoused older adults (55+ years) and primarily being discharged from hospitals in Orange County. The program will offer full on-site medical, dental, behavioral, and optical care with the option to reside at the center until permanently housed. Enrollment in the PACE program will continue post-discharge ensuring continued access to medical and social services, and tenancy services.	CalOptima Health continues to work with our broker to identiy a building and/or land that will meet the programmatic needs of this project. Meetings with interested cities continue to be held to explore potential sites. A meeting with Anaheim was held in November, and a meeting with Santa Ana is scheduled for February 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Identify and secure a building and complete necessary renovation.	Close escrow on building. Complete architectural drawings and approvals. Secure a general contractor. Complete renovations.	Working with our broker to identify a building.
Ensure members discharged from the program are connected to permanent and/or supportive housing.	80% of older adults discharged from the program will be connected to permanent and/or supportive housing.	TBD
Ensure members discharged from the program continue to receive medical support from the PACE program.	75% of older adults discharged from the program will continue to receive PACE services.	TBD
Ensure members discharged from the program remain permanently housed.	75% of older adults discharged from the program will remain permanently housed 2 years post discharge.	TBD
Delivery of care to CalOptima Health members who are eligible for the program.	75% of older adults in the program will successfully utilize the services offered	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/14/25	**Initiative Name:**	Garden Grove Recovery Center Development and Maintenance	**Start Date:**	9/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$10.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Street Medicine Support Center is a service-enriched supportive housing facility focused on providing individuals enrolled in the Garden Grove Street Medicine Program with continued medical wraparound services, housing navigation, and Enhanced Care Management. These services will assist in retaining housing, improving health status, and maximizing the ability to live and (if applicable) work in the community. There will be 50 furnished, private rooms and an outdoor space for socialization and overall mental wellness.	Architect contract executed. Working with architect to complete the program and drawings.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure Architectural firm and complete design and plan approval process	Firm contracted and plans approved by City of Garden Grove	Archtiect contract has been executed. Currently working with the firm to complete design and plan approval process.
Complete Construction	Certificate of Occupancy secured date	Once the architectural drawings are complete, we will start the process of identifying a general contractor and create construction timeline and completion date.
Secure a provider	Contract with HealthCare in Action successfully executed	Will begin the process of securing a provider once the consruction timeline is developed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	General Awareness and Brand Development	**Start Date:**	4/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2026
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$4.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To create and implement a General Awareness and Brand Development campaign that will support enhanced recognition of CalOptima Health's key role in the community, improve understanding of our values and vision, and contribute to the strategic priority of promoting CalOptima Health's voice and influence. The audience for this campaign includes members, providers, community stakeholders, elected officials, CalOptima Health staff and the general public.	The launch of all new assets was completed in Q2 of FY25, including print, digital, outdoor and TV formats. We are planning for new executions in the second half of FY25, including at the Orange County Fair and gas pump locations.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Brand platform development and consulting	Research, strategy, brand messaging and design platforms, brand concept and guidelines	- Completed a refresh of the General Awareness and Brand Campaign, spending $250,000 on new campaign assets.
Campaign creation and execution	Media plan, campaign development and campaign production	- Original campaign assets/ads were completed in FY23 - Refreshed campaign creatives were developed Jul-Sep 2024 for print and digital media ads (TV/video, digital banner and social media ads) in partnership with Maricich Health.
Campaign media buys	Media placements, monitoring and reporting	- Original media plan was developed in FY23 and executed in FY23-FY24. - Media plan for additional funds was developed. - Ad placements started in Jul 2024 for digital media and Nov 2024 for print media. - Projected media spend for FY25 is $1,000,000.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/25	**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Oct-Dec (Q2)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program is currently operational in three cities: Garden Grove, Costa Mesa and Anaheim. The team sought board approval to expand the program to one new city in 2025. - HCAP continues to operate at 12 shelter sites through the partnership of six local community clinics and homeless shelter operators.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop two new programs and/or services to meet the unique needs of our members experiencing homelessness.	Program implementation	Developed and launched and continue to maintain the Homeless Clinic Access Program (HCAP) and the Street Medicine program.
Provide 200 participants with point of care service through each of the Garden Grove, Anaheim and Costa Mesa Street Medicine programs.	Number of members served	394 members have been served by the Garden Grove Street medicine team. The Costa Mesa team served 44 individuals and the Anaheim team served 89 members.
Connect 90% of members served through the Garden Grove Street Medicine program to enhanced care management and community supports.	Percent of members connected	99% of individuals enrolled in the Street Medicine program are enrolled in enhanced care management, community supports, or both.
Connect 80% of members served through the Garden Grove Street Medicine program to a primary care physician (PCP).	Percent of members connected	99% of members are actively connected to a PCP.
Connect 25% of members served through the Garden Grove Street Medicine program to housing.	Percent of members connected	13% of members have been connected to a shelter or permanent housing. This number continues to trend upwards as staff have time to build relationships with the members and identify potential housing for them.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/25	**Initiative Name:**	Housing and Homelessness Incentive Program	**Start Date:**	04/01/22
Reporting Period:	Oct-Dec (Q2)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$87.4 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
HHIP is a voluntary program that aimed to improve health outcomes and access to whole person care services by addressing housing insecurity and instability for the Medi-Cal population. Through this program, CalOptima Health earned $72.9 million of the $83 million for which it was eligible. These funds have been and will continue to be invested into the community to improve the experience of members at-risk for and experiencing homelessness.	- A progress report was created and shared with the CalOptima Health Board of Directors, demonstrating impact achieved since the start of HHIP. This also included recommendations for how to continue allocating the awarded funds across the funding priority areas. - Awarded 123 grants in various stages of implementation and include new programs developed and launched including the Whatever It Takes program conducted by United Way, the Pulse for Good consumer feedback program, and the Nonprofit Healthcare Academy that is currently engaging its second cohort of nonprofit providers. - Staff will launch the 4th HHIP funding opportunity in Jan 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Address housing insecurity and instability among Medi-Cal members.	Earn $83.7M in incentives	Earned $73 of the potential $83.7M (87%).
	Percentage increase / increased number of housed members among unhoused members	Increased percentage and number of unhoused members housed from 1.3% in June 2022 to 34.3% as of October 2023, representing 3,585 members.
	Percentage of members that stayed stably housed	Of members experiencing homelessness in early 2023 that were connected to housing, 69% remained housed through April 2024 (the next measurement period).
Expend all funds contributed to this effort.	Number of grant awards	123 grant awards have been made and are in various stages of implementation.

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization (this column repeats on the next page)	HHIP NOFO Round	Address	SPA	Contract Execution Date	Contract End Date	Total Contract/ Agreement Amount
City of Anaheim - Housing and Community Development Department	2	9150 E. Orangewood Ave. Anaheim, CA 92802	North	12/1/2023	12/1/2024	$1,500,000.00
Community Action Partnership OC	1	10821, 10786, 10782, 10881 Garza Ave. (Senior Duplex units A and B), Anaheim, CA 92802 9301 Katella Ave. (Duplex units A and B), Anaheim, CA 92804	North	4/1/2023	3/31/2024	$98,340.00
The Salvation Army Orange County	1	1401 S. Salvation Pl., Anaheim, CA 92805	North	6/1/2023	3/31/2024	$4,100,000.00
Jamboree Housing Corporation	2	1108 N. Harbor Blvd., Santa Ana, CA 92703	Central	12/1/2023	12/1/2024	$4,721,241.00
National Community Renaissance of California	2	1314 N. Angelina Dr., Placentia, CA 92870	North	12/1/2023	12/1/2024	$1,334,677.00
WISEPlace	2	23240 Orange Ave. #4, Lake Forest, CA 92630	South	12/1/2023	11/30/2025	$1,000,000.00
Pathways of Hope OC	1	504/506 W. Amerige Ave., Fullerton, CA 92832	North	4/1/2023	3/30/2025	$1,500,000.00
Mercy Housing California	2	480 S. Batavia St., Orange, CA 92868	North	12/1/2023	12/1/2025	$1,500,000.00
Golden State Recuperative Care	3	150 Cecil Place, Costa Mesa, CA 92627	Central	6/1/2024	5/31/2034	$3,500,000.00
Mind OC/Be Well OC	3	7800 Marine Way, Irvine, CA 92618	South	6/1/2024	5/31/2034	$5,000,000.00
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	2	617, 625, 637 W. La Veta Ave., Orange, CA 92686	North	12/1/2023	12/31/2025	$1,400,000.00
Illumination Foundation	2	918 N. Bewley St., Santa Ana, CA 92703	Central	12/1/2023	11/30/2025	$3,000,000.00
Community Development Partners	2	2274 Newport Blvd., Costa Mesa, CA 92627	Central	1/1/2024	12/1/2025	$8,000,000.00
Kingdom Causes dba City Net	2	8694 Western Ave., Buena Park, CA 90620	North	12/1/2023	6/30/2026	$1,337,170.49
Friendship Shelter	1	2435 S. El Camino Real, San Clemente, CA 92672	South	4/1/2023	9/30/2025	$3,850,000.00
Anaheim Housing Authority	2	1251 N. Harbor Blvd., Anaheim, CA 92801	North	12/1/2023	12/1/2025	$3,878,420.00
City of Yorba Linda	2	5086 Avocado Circle, Yorba Linda, CA 92886	North	12/1/2023	12/1/2024	$3,100,000.00
Families Forward	2	1852 San Juan St., Tustin, CA 92780	Central	12/1/2023	12/1/2025	$2,500,000.00
American Family Housing	1	15222 Jackson St., Midway City, CA 92655 and 15081 Adams St., Midway City, CA 92655	Central	6/1/2023	3/31/2028	$2,951,660.00
The Eli Home, Inc.	2	3175 W. Ball Road, Anaheim, CA 92804	North	12/1/2023	12/1/2026	$5,000,000.00
City of Anaheim/Anaheim Housing Authority	1	120 S. State College Blvd., Anaheim, CA 92806	North	5/1/2023	4/30/2026	$2,000,000.00
Korean Community Services dba KCS Health Center	1	13091 Galway St., Garden Grove, CA 92844	Central	4/1/2023	3/31/2026	$2,500,000.00
Hart Community Homes	3	220 N. Lemon St., Fullerton, CA 92832	North	6/1/2024	5/31/2034	$4,000,000.00
Illumination Foundation	3	3708 W. Washington St., Santa Ana, CA 92703	Central	6/1/2024	5/31/2034	$3,500,000.00
Casa Youth Shelter	3	10935 Reagan St., Los Alamitos, CA 90720	North	8/1/2024	7/31/2034	$4,000,000.00
Orange County Housing Finance Trust	1	N/A as these ADUs will be cross-county	ALL	5/1/2023	4/30/2027	$4,000,000.00
C&C Development	2	7101 Lincoln Ave., Buena Park, CA 90620	North	1/1/2024	12/1/2026	$8,000,000.00
City of Brea	2	323 N. Brea Blvd., Brea, CA 92821	North	12/1/2023	12/1/2027	$6,028,491.51

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization	Projected Completion Date	Number of Units Proposed	Number of Units Completed	Previous Site Visit Dates	Next Site Visit Dates	Total Payments To Date	Total Payments Remaining	Grant Open or Closed
City of Anaheim - Housing and Community Development Department	12/30/2023	102	102	10/22/2024	N/A	$1,500,000	$0	Closed
Community Action Partnership OC	3/31/2024	5	5	9/28/2023	N/A	$98,340	$0	Closed
The Salvation Army Orange County	3/31/2024	72	72	6/22/2023	N/A	$4,100,000	$0	Closed
Jamboree Housing Corporation	3/31/2024	91	91	11/20/2024	N/A	$4,721,241	$0	Closed
National Community Renaissance of California	7/30/2024	65	65	12/2/2024	N/A	$1,334,667	$0	Closed
WISEPlace	11/30/2025	5		12/20/2024	6/18/2025	$1,000,000	$0	Open
Pathways of Hope OC	12/31/2024	15		9/25/2024	N/A	$1,500,000	$0	Open
Mercy Housing California	1/30/2025	50	50	12/9/2024	N/A	$1,500,000	$0	Closed
Golden State Recuperative Care	3/31/2025	30		1/14/2025	7/13/2025	$2,000,000	$1,500,000	Open
Mind OC/Be Well OC	5/31/2025	35		-	-	$0	$5,000,000	Open
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	12/31/2025	6		11/19/2024	5/18/2025	$1,400,000	$0	Open
Illumination Foundation	11/30/2025	11		11/7/2024	5/7/2025	$3,000,000	$	Open
Community Development Partners	8/1/2025	87		9/18/2024	3/17/2025	$8,000,000	$0	Open
Kingdom Causes dba City Net	6/30/2026	20		????	3/1/2025	$1,337,170	$0	Open
Friendship Shelter	9/30/2025	11		10/30/2024	4/28/2025	$3,850,000	$0	Open
Anaheim Housing Authority	9/30/2025	89		10/22/2024	4/20/2025	$3,878,420	$0	Open
City of Yorba Linda	9/30/2025	66	64	11/13/2024	N/A	$3,100,000	$0	Closed
Families Forward	11/1/2025	8		10/31/2024	4/29/2025	$2,500,000	$0	Open
American Family Housing	3/31/2028	111		10/31/2024	4/29/2025	$2,951,660	$0	Open
The Eli Home, Inc.	2/1/2026	11		-	3/1/2025	$5,000,000	$0	Open
City of Anaheim/Anaheim Housing Authority	3/31/2026	32		10/22/2024	4/20/2025	$2,000,000	$0	Open
Korean Community Services dba KCS Health Center	3/31/2026	100		9/18/2024	3/17/2025	$2,500,000	$0	Open
Hart Community Homes	5/30/2026	20		11/6/2024	5/5/2025	$0	$4,000,000	Open
Illumination Foundation	5/30/2026	30		11/7/2024	5/7/2025	$1,895,575	$1,604,425	Open
Casa Youth Shelter	7/31/2026	14		12/12/2024	6/10/2025	$0	$4,000,000	Open
Orange County Housing Finance Trust	4/30/2027	34		11/30/2023	TBD	$4,000,000	$0	Open
C&C Development	1/30/2027	55		10/24/2024	4/22/2025	$8,000,000	$0	Open
City of Brea	5/31/2027	40		4/27/2025	10/29/2024	$6,028,492	$0	Open
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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/13/2025	**Initiative Name:**	In-Home Care Pilot Program	**Start Date:**	9/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	8/31/2025
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$2.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health has contracted with UCI to partner with home-based care Dispatch Health services to provide services to all CalOptima Health members assigned to a UCI FQHC with acute medical needs. The program provides same-day high acuity care, focused medical intervention within 24 to 72 hours post discharge, and hospital-at-home alternative care in lieu of hospitalizations.	Program expanding and being utilized successfully to appropriate members to ensure reduction in unnecessary hospital and ER visits. Evidence shows that there was a better coordination of care, increased patient satisfaction and reduction in avoidable utilization for acute care patients. CalOptima Health continues to meet with UCI leadership to expand the program to other newly acquired UCI facilities such as Fountain Valley. We are also coordinating care with the UCI embedded CalOptima Health nursing staff.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve access to in-home acute care	Number of members seen in in-home acute care	248 members were seen in in-home acute care that were referred by UCI FQHCs *Data is from Jan - Dec 2024
Reduce emergency department (ED) visits by 20%	Percentage of members seen through in-home acute care instead of ED	109 members seen in in-home care acute care *Data is from Jan - Dec 2024
Achieve utilization of Dispatch Health by at least 10%	911 Diversion Rate	11.6% of members were diverted to Dispatch Health in place of 911 service *Data is from Jan - Dec 2024
Reduce hospital observation stay by 10%	Observation Diversion Rate	8% of members seen by Dispatch Health were observed in ED *Data is from Jan - Dec 2024
Reduce hospital admission by 10%	Hospital Diversion Rate	2.1% reduction of hospital admission for members seen by Dispatch Health *Data is from Jan - Dec 2024

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	Member and Population Health Needs Assessment	**Start Date:**	2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2025
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Conduct a comprehensive Member and Population Health Needs Assessment (MPHNA) and Health Equity Asset Mapping (HEAM) to assess the whole-person health needs and preferences of CalOptima Health members, inform the development of programs and strategic approaches and to meet the requirements of the Medi-Cal Population Needs Assessment (PNA) and address health equity.	- The RFP for contractor/vendor has been released. A competitive review process of responses is currently in flight. - Recommended contractor/vendor will be presented to the Board of Directors for approval in March 2025 Board of Directors meeting.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Support meeting the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, (PNA), and Medi-Cal Transformation initiatives.	Deployment of MPHNA	MPHNA implementation scheduled for March 2025
Identify trends and opportunities in population health and social needs of CalOptima Health members.	MPHNA report findings produced	TBD - not yet started
Identify assets and resources avaliable in the community and conduct gap analysis.	Detailed community asset mapping and list of community investment opportunities through an interactive dashboard produced	TBD - not yet started
Develop recommendations for interventions based on assessment findings.	Final report with actionable strategies and recommendations developed and presented	TBD - not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	Mind OC Grant (Irvine)	**Start Date:**	12/1/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	10/31/2024
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$15.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Mind OC received grant funding to support the construction of the second Be Well OC Campus in Irvine, CA to provide best-in-class mental health and substance abuse services to all, regardless of payer. The first phase of campus development will include 75,000 sq ft. of crisis care, outpatient and residential/short term treatment options. The services are planned to support a full continuum of care needs, and will offer programs for adults, adolescents, and families (through wraparound supports).	- Site readiness activities completed. Phased operational construction on track with building progress. - Grant amendment, effective October 2024, transferred balance of grant ($6,169,080) to Argent, a third-party trust, to disburse remainder of grant funds on a monthly schedule. - Under amendment, Mind OC to submit monthly progress reports to reflect progress of design and construction. - CalOptima completed review of Dec monthly report and processed 1 of 8 payment disbursements. - CalOptima to continue to monitor objectives 1-3 per amendment, with next quarterly report due 3/31/2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Package 1: Site Readiness activities, to prepare site for the construction of 75,000 square feet of the Be Well Irvine Campus – Phase 1	% of site readiness activities completed and scheduled	100% completed: Demolition, abatement, rough grading and future building pads completed by August 2023.
Complete Package 2 construction for Be Well OC Irvine Campus, and buildings ready for phased operational go-live.	% of building construction based on procurement and construction schedule	75% complete: exterior cladding complete, interior walls in progress, and progressing on key water/gas/electric connections Current building schedule set for completion late March/early April 2025.
Align public and private funding to execute on the capital financing needed for Phase 1 development, for a total of $86 million.	$ amount of secured capital financing for funding Phase 1 development	100% completed: $82.7M in cash; $3.2M secure via fund flow contract with County of Orange.
Facilitate the process of provider selection and contracting for service provision at the Campus	% completion of selection process and contracting for service providers	Objective is no longer applicable as the Orange County Health Care Agency terminated the Master Service Agreement with MindOC, and is now leading the effort to select providers.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	Mind OC: Be Well OC Orange Campus Intake & Admissions	**Start Date:**	3/1/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2/29/2024
Program Status:	Complete	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Be Well Orange Campus will build an intake and admissions coordination capability to best meet the needs of the community and ensure excellence in access, assessment, placement into care, and referrals when indicated. The intake and admissions team will work closely and collaboratively with OC Links and other County and CalOptima Health functions necessary to coordinate appropriate placement into care.	- Call Center Software for all calls to be routed through one line - HOPE Central - implemented June 2024. - Anticipated rollout of client and referral partner satisfaction surveys in Fall/Winter 2024. - Care Navigation program ended October 1, 2024. - Confirmed receipt of remaining balance of grant repayment January 2025. - Close-out procedures currently in progress, pending final close-out report review to be completed in February 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Onboard program staff with one Intake Supervisor and two Intake Counselors to support Phase 1	-Position descriptions created for each role -Each position posted for recruiting -Number of qualified respondents for each position -Qualified candidate hired for each position	100% completed: 3 intake navigators and 1 supervisor were hired after April 2022.
Program staff are appropriately trained with ongoing professional development	-Training plans developed for each role -Necessary training completed by each staff member annually -Performance review completed annually	100% completed: Hired staff completed appropriate training with ongoing professional development.
All campus programs are accessible to all clients and referral partners via a single phone number.	-Monthly inbound call volume -Monthly volume of calls handled by intake team versus calls routed to campus providers or other programs	100% completed: 1) Call Center Software implementation began on June 11, 2024; 2) June 2024 – August 2024 call volume - 2,795 calls, averaged 967 calls per month; 3) 94% of callers who called for program admission were accepted to a program. 4) Contract terminated August 29, 2024
Adapt and/or augment monthly Campus dashboard to support intake program reporting needs	-Monthly dashboard produced and disseminated -Number of individuals and organizations that the dashboard is shared with	100% completed: 1) Salesforce was adapted to capture relevant data elements; 2) Developed and published monthly dashboards on Care Navigation Team impact to the community (Providers, Partners, and Community Stakeholders) through Exodus and HR360.
3,600 people served each year through intake and admissions coordination program for Be Well Orange Campus	-Monthly volume of clients served -Quarterly volume of outreach activities, including number of individuals and organizations reached -Client and referral partner satisfaction surveys	100% completed: 1) Served 5,074 unique clients; 2) Submitted 45 Medi-Cal enrollment applications; 3) Provided 720 clients to SUD referrals, 460 Mental Health referrals, 136 Housing and Shelter referrals

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/11/2025	**Initiative Name:**	Naloxone Distribution Event	**Start Date:**	07/01/23
Reporting Period:	Oct-Dec (Q2)			**End Date:**	07/01/25
Program Status:	In Progress	**Initiative Owner:**	Veronica Carpenter	**Approved Amount:**	$15.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health will implement the Naloxone Distribution initiative to increase access to Naloxone for members, with the goal of reversing fentanyl and opioid overdoses and saving lives.	Through partnerships with community based organizations (CBOs), providers, recovery coalitions, and direct member outreach, CalOptima Health will distribute Naloxone throughout the community. CalOptima Health purchased 250,000 boxes of Naloxone for distribution. To date, we have approximately 62,000 boxes remaining of the 250,000 boxes purchased. A mail order option will increase the community's access.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Purchase 250,000 doses of naloxone for distribution	Purchase Kloxxado (8 ml prescription-strength naloxone)	250,000 boxes
Conduct events and community outreach to distribute naloxone to members	Offer naloxone at community events in various places throughout the county	Hosted one distribution event for members and two events for providers and community organizations. Approx. 23,940 boxes distributed at these events. Additionally, Naloxone distribution was also included in 6 community events.
Engage providers, community organizations, city governments, public agencies, school districts and others in helping to distribute naloxone to members	Create a process for providers and other partners to obtain the naloxone using a distribution agreement	CalOptima Health hosted two Naloxone distribution events for providers and community based organizations.There were 73 attendees and 23,604 boxes of Naloxone distributed at these events.
Create a training video and communications resources to promote naloxone distribution and education	Develop sharable resources for communications and education	Training video and FAQs are posted online at www.caloptima.org/naloxone (approximately $5,000 spent)
Establish a partnership with recovery coalitions to provide access to Naloxone	Offer an ongoing and routine allocation of Naloxone for members who are affiliated with a recovery coaltion.	CalOptima Health has established relationships with Recovery Road and Fentanyl Solutions to distribute Naloxone to our members and community. Both organizations receive 3 pallets of Naloxone (totaling 750 boxes) every other week.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	NAMI Orange County Peer Support Program	**Start Date:**	1/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$5.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
NAMI pairs trained Peer Support Mentors with CalOptima Health members to provide tailored, social support and resource navigation from hospital inpatient stay/emergency room visit to six months post-discharge. Peer Support Mentors facilitate members in scheduling and attending follow-up primary care appointments (especially post-discharge).	Year 1: Majority of staff were hired and trained within the first 6 months. Additional staff has been on-boarded to support the increased efforts to grow the program participation. Year 2: Current enrollment rate into the program = 66%. - CalOptima Health and NAMI are partnering to further refine reporting metrics/analysis. COH BH and CalAIM developed strategy to improve awareness to increase program participation to meet the program goals. - Identified opportunities for increased referrals to program: 1) Connect NAMI with Telemed2u for partnership and referrals; 2) Connect NAMI to ED leadership with higher number of members; 3) CalOptima Health provide NAMI with member contact information and approved script, for NAMI peers to reach out to.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Facilitate behavioral health transitions from hospital to home/community	Facilitate behavioral health transitions for 65% of those who are referred to the program (N=eligible members referred from hospital or ED). Success = 2+ months	Currently at 43%; Limitations around expanding partnerships with additional Emergency Departments. Working with BH team on reaching more members.
Support behavioral health integration through Peer facilitating member connection to ECM.	NAMI Peer program, connect 75% of members eligible for ECM who aren't already receiving the benefit. (i.e., the member receives an authorization for ECM)	Currently at 79%; Exceeding the goal of 75%.
Improve CalOptima Health's HEDIS FUM1 measure	For members who are referred to the program, 85% achieve a follow-up appointment either 7 or 30 days after hospital or ED discharge	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Working with CalOptima to cross-check member utilization post-engagement with program.
Reduce readmissions at psychiatric hospital through family and resource connection	25% reduction in psychiatric hospital admissions for members referred from the ED and having completed the program	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Working with CalOptima to cross-check member hospitalization rates post-engagement with program.
	25% reduction in psychiatric hospital re-admissions for members referred during an inpatient stay *Establish baseline during year 1*	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Working with CalOptima to cross-check member hospitalization rates post-engagement with program.

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Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	OneCare Outreach and Engagement Strategy	**Start Date:**	07/01/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2025
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$1.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Expansion of the CalOptima Health OneCare outreach and engagement strategy to enroll and retain eligible CalOptima Health members who are also enrolled in Medicare.	The BOD authorized extension of timeframe to implement the CalOptima Health OneCare outreach and engagement strategy to June 30, 2025. The remaining funds ($630,000) were allocated for use in objective #1. Details of progress is listed below. Additional buys are being coordinated for Q3 and Q4 of this fiscal year.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase outreach for CalOptima Health OneCare through continuous and heavy presence in the market with a full range of advertising tactics.	Number of media buys	For Q2, we extended the OCTA bus ads (originally slated to end mid-December 2024) to run through March 2025. We also started work on the development of animated explainer videos, which will be completed by the end of this FY.
Retain existing CalOptima Health OneCare members with targeted mailings.	Number of members retained	As stated in the FY24 (Q4) report, we sent two retention mailers to members during that period. There was a decrease in disenrollment (i.e. increased retention) during the months that the retention mailers were sent, as compared to prior month; April 2024 (8.5% decrease) and June 2024 (5.9% decrease).
Increase direct mail outreach to prospective OneCare members by customizing messages and segmenting the mailing	Number of direct mailers sent to three segmented audiences (FFS members, members of another MA plan, Former OneCare members)	This strategy was implemented in October 2024 with FY25 budget funds and in coordination with the new campaign roll out. We did not use funds from this initiative for this strategy.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/7/2025	**Initiative Name:**	Provider Workforce Development	**Start Date:**	12/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	FY 2028-2029
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Provider Workforce Development initiative was approved to close gaps in Orange County ' s health care workforce and increase access to high-quality, equitable care for CalOptima Health members. The five initiatives include: educational investments to increase supply of health care professionals (non-physician), the Workforce Training & Development Innovation Fund, the Physician Recruitment Incentive Program, the Physician Loan Repayment Program, and the Orange County Health Care Workforce Development Collaborative.	- Round 1 focused on educational investments to increase the number of health care professionals. - Semi-Annual progress reports received and in process of review for 6 grantees. Upcoming progress report due for Concordia 2/28/2025. - Round 2 focused on innovative solutions for training, development, and retention of health care professionals, with an emphasis on Behavioral Health. - Grant implementation for grantees began 1/1/2025. - Feedback follow-up calls with grant applicants to discuss scoring in process.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement Educational investments to increase supply of health care professionals (non-physician)	Number of health professionals in an educational program and/or receiving financial support	Estimate of approximately 1,500 health professionals
Launch Workforce Training & Development Innovation Fund	Number of behavioral heath care professionals receiving training and/or development	Estimate of approximately 350 behavioral health care professionals
Implement Physician Recruitment Incentive Program	Number of physicians recruited to close network gaps	TBD - has not started
Implement Physician Loan Repayment Program	Number of physicians receiving loan repayment awards	TBD - has not started
Develop Orange County Health Care Workforce Development Collaborative	Launched collaborative to increase the health care workforce in Orange County	TBD - has not started

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CalOptima Health

Community Investment Status Report
Initiative: Provider Workforce Development

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Chapman University	1	Reflecting OC Communities: Building a Culture of health through PA scholarships,training, local practice	7/1/24 - 12/31/29	7/24-11/24: 4 PA Students received full tuition scholarships	$ 5,000,000	$ 413,025	In Progress
Coast Community College District	1	Orange County Dual Enrollment Nursing and Allied Health Pathways	5/1/24 - 5/31/28	5/24-10/24: Golden West College nursing pipeline implementation	$ 2,040,000	$ 420,000	In Progress
Concordia University	1	Concordia Nursing Pipeline Program	8/1/24 - 8/1/29	Goal: provide scholarships to 10 pre-nursing & 20 ABSN students per year	$ 5,000,000	$ 792,880	In Progress
CSU Fullerton Auxiliary Services Corporation	1	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in OC	7/1/24 - 6/30/29	7/24-1/25: 10 RN-BSN stipend recipients; 54 BSN received stipends	$ 5,000,000	$ 971,357	In Progress
Orange County United Way	1	UpSkill OC	5/1/24 - 4/30/27	5/24-10/24: 17 UpSkill participants enrolled in healthcare career track	$ 1,356,300	$ 452,100	In Progress
Rancho Santiago Community College District	1	SCC Healthcare Pathways - Behavior Technician, LVN and Medical Assistant Projects	5/1/24 - 6/30/27	5/24-11/24: Classroom for Medical Assistant secured	$ 1,200,000	$ 775,219	In Progress
UCI Sue & Bill Gross School of Nursing	1	Nurse-OC: UCI Nursing Workforce Pipeline through Externships and Residencies in Orange County	5/1/24 - 6/30/29	5/24-10/24: 15 prelicensure nursing students placed in externship	$ 5,000,000	$ 538,869	In Progress
Child Guidance Center	2	Help the Helper: Strengthening Orange County's Behavioral Health Workforce	1/1/25 - 12/31/27	Goal: train 35 master's and doctoral students in mental health over 3 years	$ 766,920	$ 216,810	New
CHOC	2	Pediatric Behavioral Health Field Training Expansion	1/1/25 - 12/31/28	Goal: train 92-96 social work and psychology students	$ 994,824	$ 248,706	New
John Henry Foundation	2	Psychologist and MFT Workforce Development Program	1/1/25 - 12/31/29	Goal: train 25 PhD & PsyD candidates & MFT students	$ 847,302	$ 155,390	New
Seneca Family of Agencies	2	Seneca Family of Agencies Orange County Behavioral Health Clinical Internship Program	3/1/25 - 6/30/28	Goal: train 18 master's students in mental health	$ 996,160	$ 179,030	New
Special Service for Groups	2	Professional Providers Pathway Program	1/1/25 - 12/31/29	Goal: train 25 graduate students in behavioral health	$ 535,566	$ 106,622	New
Western Youth Services	2	WYS Workforce Development Program	1/1/25 - 12/31/29	Goal: tuition reim-55 staff; stipends-35 master's interns; licensure reimb-80 staff	$ 1,000,000	$ 200,000	New
					$	$	
					$	$	
					$	$	

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/6/2025	**Initiative Name:**	Stipend Program for Masters of Social Work	**Start Date:**	8/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	7/31/2028
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$5.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Orange County Behavioral Health (OCBH) Master of Social Work Stipend Program will increase the public healthcare workforce from diverse backgrounds equipped to provide culturally and linguistically responsive care to communities in need. The program will provide a stipend of $20,000 per academic year for up to two (2) years to 36 MSW students each year at CSUF (as they receive enhanced didactic and experiential training).	- 36 students successfully completed the OCBH program for 2023-2024 academic year: 14 graduated May 2024; 21 students are continuing for their second year; 1 student chose not to continue with the stipend program - 15 grant recipients left the OCBH program with a one-year work commitment within Orange County - All 14 graduating stipend students achieved scores of 3 or higher on all nine social work competency measures, surpassing the 85% benchmark - CSUF reported mitigating identified challenges w/ stipend disbursement procedure by initiating process early for 2024-2025 academic year

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Double the number of MSW field placements that focus on behavioral health practice with persons from vulnerable communities from 70 to 140 over 5 year grant period.	Number of MSW field placements	70 MSW student placed in first academic year 25 new placement spots added for students within new and existing partner agencies
Award stipends to 108-180 MSW students who fully participate in the CalOptima MSW Stipend Program over 5 year grant period.	Number of students completed the Grant Program	36 stipends were awarded during the academic year 2023-2024; 14 recipients graduated in May 2024
Develop an enhanced curriculum on behavioral health including digital health literacy and telehealth.	Students' clinical competency measured by quantitative and qualitative evaluation methods	Feedback from enhanced curriculum, Simucase, has been overwhelmingly positive, prompting the Social Work Department to integrate Simucase into all MSW advanced practice courses for the 2024-2025 academic year
Offer Career Development Services to all CalOptima MSW Stipend Program students and follow up regarding employment at 1-year post-graduation.	Number of former students with post-graduate employment	-Year 1 Post-graduation employment outcome will be assessed 6 months from graduation; will be reported in the Year 2 semi-annual report (March 2025) -Program exit survey indicated 2 recipients had already accepted job offers within Orange County before their graduation from the MSW program

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	Wellness Prevention Program	**Start Date:**	7/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2028
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$2.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This project will supplement the Mental Health Service Oversight and Accountability Commission (MHSOAC) funding to support establishment of full clinical operations and prepare Allcove South Orange County Youth Drop in Center to create sustainable service streams. Delivery of services will be supported by FTE positions learning opportunities through Stanford CAT.	- Construction is set to begin mid-January 2025. Construction costs about 10% above budget - will reallocate and supplement with additional funding. - In partnership with Youth Advisory Group (YAG), finalized architectural and branding plans, with furniture selected and ordered end of January 2025. - Working with contractor to respecify materials with long lead times. Next progress report due July 2025. - Grand Opening delayed until 9/2025 to allow for larger attendance.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure a location for Allcove in South Orange County	Location secured successfully	- Secured 10,000 sq ft location for Allcove in South Orange County San Juan Capistrano.
Staff recruitment	Number of hired staff - positions to support delivery of care services in allcove model	- 4 staff members have been hired. - Began interviewing site manager and peer support specialists.
Establish intake data collection	Data collection system implementation	- Staff is working with allcove Team to integrate allcove datacove into intake data collection.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	Comprehensive Community Cancer Screening and Support Program	**Start Date:**	12/02/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Dr. Richard Pitts	**Approved Amount:**	$50.1 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care.	Accomplishments: 1) Held the grantees' kickoff meeting on 10/2/24. 2) Hosted a virtual webinar to provide reporting instructions on 11/8/24. 3) Met with individual grantees (ACS, TFG) to provide support. 4) Deployed 1-way text messages for BCS and CCS through mPulse. 5) Worked on an RFP for a research and evaluation initiative (work in progress). Barriers/Challenges: 1) Change in project management leadership, several critical operational requirements were identified (e.g., BAA, data exchange approval process, grant amendment, etc.) causing delay. 2) Focus on releasing an RFP.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase community and member awareness and engagement	Develop and launch a multimedia, multilingual campaign within the first four years of the program (*Data provided by Maricich)	28.7 Million Campaign Digital Ad Impressions; 0.30% Click-Through Rate (CTR); 15 Million Digital Added Value Impressions; 2.9 Million Completed Video Views; 87.2K Digital Clicks to Landing Page
Increase access to cancer screening for eligible member	Develop and implement a community grant initiative by year two of the Cancer Screening and Support program	Community Grants 1 successfully launched in September 2024. From October through December 2024, all 13 grantees initiated their grant program and provided their first quarterly progress report (Sep - Nov 2024).
	# of CalOptima members who received appropriate cancer screening	Several grantees reported the number of COH members served this quarter - refer to next page for details
Improve quality and member experience during cancer screening and treatment procedures	Extend vendor contract(s) to support members through screening, diagnosis and cancer treatment starting in Year 2	TBD
	Establish contract to evaluate cancer incidence, experiences, and genomic technologies to reduce disparities in late-stage cancer diagnosis by Year 2	Focus has shifted to releasing an RFP. SOW is being worked on.

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CalOptima Health

Community Investment Status Report
Initiative: Cancer Screening and Support

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
American Cancer Society, Inc.	1	Advancing Equitable Outcomes Across the Cancer Continuum for CalO Members and Greater OC Area	9/1/24 - 8/31/26	Est. to serve 54,500 COH members	$ 1,500,000	$ 375,000	In Progress
Celebrating Life Community Health Center	1	Using Technology Infrastructure to Close Gaps in CCS	9/1/24 - 8/31/26	Est. to serve 2,500 members. Improve CCS, BCS, COL each 15%, lung 25%	$ 329,428	$ 82,357	In Progress
Celebrating Life Community Health Center (2)	1	Closing Gaps in Cancer Screening	9/1/24 - 8/31/26	Est. to serve 2,500 COH members	$ 1,290,575	$ 322,643.75	In Progress
Families Together of Orange County	1	C3 Health Initiative: Cervical, Colorectal and Breast Cancer Screening Program - Capacity Building	9/1/24 - 8/31/26	Screenings for early signs of breast, cervical, and colorectal cancer.	$ 1,500,000	$ 375,000	In Progress
Friends of Family Health Center	1	Standardizing Screening Mammograms within Primary Care Setting	9/1/24 - 8/31/26	Est. to target 4,500 COH members with on-site mammography services	$ 554,875	$ 138,718.75	In Progress
Hurtt Family Health Clinic, Inc.	1	Universal Cancer Screening Program: SDOH, Patient Motivation to Early Detection & Timely Access to Care	9/1/24 - 8/31/26	Est. to serve 3,500 members. To date: CCS:94, COL:111, BCS:150	$ 1,018,600	$ 254,650	In Progress
Korean Community Services, Inc.	1	Orange County Asian American Cancer Partnership (OCAACP)	9/1/24 - 8/31/26	9/24-11/24: BCS:544, COL:730, CCS: 339, & Lung:55	$ 3,000,000	$ 750,000	In Progress
Laguna Beach Community Clinic	1	Cancer Screening and Support for Disadvantaged Patients	9/1/24 - 8/31/26	9/24-11/24: BCS: 94, COL: 193, CCS: 246	$ 116,000	$ 29,000	In Progress
Latino Health Access	1	Juntes Contra el Cancer! / Together Against Cancer!	9/1/24 - 8/31/26	Est. to serve 500 COH members through CHW/Promotor workforce.	$ 1,500,000	$ 375,000	In Progress
mPULSE Mobile, Inc.	1	Equitable Cancer Prevention with Targeted Member Screening Communications	9/1/24 - 8/31/26	One-Way messages to members 12/24: 13,318 for BCS, 65,763 for CCS.	$ 1,197,625	$ 299,406.25	In Progress
Share Ourselves Corporation	1	Share Ourselves: Cancer Screening	9/1/24 - 8/31/26	Est. to serve 11,900 COH members	$ 362,500	$ 90,625	In Progress
The G.R.E.E.N Foundation	1	Increasing Screening and Health Equity in OC	9/1/24 - 8/31/26	~3,500 members COH African American members	$ 295,100	$ 73,775	In Progress
UCI Family Health Center	1	Closing the Cancer Screening Gap	9/1/24 - 8/31/26	~15,979 members 9/24-11/24: 2,860 members served	$ 1,500,000	$ 375,000	In Progress
AltaMed	1	Comprehensive Community Cancer Program - Capacity Building (CCCP-CB)	9/1/24 - 8/31/26	9/24-11/24: 432 mbrs outreached, 1,136 completed scr, 290 care coordinated	$ 1,499,992	$ 374,998	In Progress
AltaMed (2)	1	Comprehensive Community Cancer Program - Infrastructure and Capital Improvements (CCCP-ICI)	9/1/24 - 8/31/26	Integration of Compass Rose for systems workflow completed: 5%	$ 752,349	$ 188,087.25	In Progress
					$	$	

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/13/2025	**Initiative Name:**	Dyadic Services Program Academy	**Start Date:**	6/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	5/31/2026
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$1.9 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
First 5 Orange County (F5OC) will develop and provide administrative oversight of the CalOptima Health Dyadic Services Program Academy to expand dyadic services capacity. The academy's objective is to increase access to HealthySteps dyadic services for members by launching 10 sustainable dyadic services programs across Orange County. F5OC will provide pre-academy planning and development, a 9-month academy, and 12-month post-academy technical assistance for each clinic.	- First 5 OC has fully conceptualized the Dyadic Care Academy and launched the program with 7 of the 10 clinics; the three remaining clinics have additional technical support needs before they can join the Academy. - First 5 OC is continuing to provide the additional technical assistance and anticipates onboarding those clinics in early to mid-2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Train 10 clinics to complete the Academy and obtain HealthySteps certification.	Number of clinics that completed the Dyadic Care Training Academy and obtained required HealthySteps certification	The Academy has just begun; data will be available at a later date.
Increase members receiving well child visits and screenings	Claims/encounter data well child and screenings	The Academy has just begun; data will be available at a later date.
Increase billing for Dyadic Services and non-speciality mental health.	Claims/encounter data Dyadic services and mental health services	The Academy has just begun; data will be available at a later date.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/7/2025	**Initiative Name:**	Five-Year Hospital Quality Program	**Start Date:**	1/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$153.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Hospital Quality Program for CalOptima Health-contracted hospitals aims to improve quality of care to members through increased quality and patient safety efforts. Program goals: 1) Support hospital quality standards for Orange County; 2) Provide industry benchmarks and data-driven feedback; 3) Recognize hospitals demonstrating quality performance; 4) Provide comparative information on network hospitals; and 5) Identify areas for improvement.	Measurement Year 2023 performance was calculated for each contracted hospital. Hospitals were notified of their performance with a scorecard containing performance scores and incentives earned. Incentive payments were issued December 2024/January 2025 totaling $15,391,218.00. See attachment.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reward contracted Medi-Cal hospitals for high performance on hospital quality of care, patient experience, and hospital safety using CMS hospital quality and Leapfrog patient safety measures.	The percentage of contracted hospitals earning hospital quality incentives. Metric equals number of hospitals earning any incentive amount divided by number of eligible contracted hospitals.	67% (14 of 21) of contracted hospitals earned hospital quality incentives.
	The percentage of hospital quality dollars awarded. Metric equals total incentives awarded divided by total annual incentive pool.	55% ($15,391218/$27,843,225) of hospital quality dollars were awarded.
Improve hospital quality	Star Rating	MY2023 average star rating is 3 stars. MY2023 will be established as baseline performance.
Improve hospital patient experience	Star Rating	MY2023 average star rating is 2.6 stars. MY2023 will be established as baseline performance.
Improve hospital patient safety	Safety Grade	MY2023 average safety grade is B. MY2023 will be established as baseline performance.

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Hospital Quality Stars Rating

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Regional Medical Center	★★★	★★	B	$1,413,638	$494,773
Anaheim Global Medical Center	N/A	★★	C	$265,834	$26,583
Chapman Global Medical Center	★	★	D	$155,157	$0
Children's Hospital of Orange County	★★★★★	★★★★★	B	$3,598,119	$3,418,213
Foothill Regional Medical Center	N/A	★	N/A	$627,218	$0
Fountain Valley Regional Hospital & Medical Center	★★	★	D	$3,456,890	$0
Hoag Memorial Hospital Presbyterian	★★★★★	★★★★	A	$1,940,663	$1,746,597
Los Alamitos Medical Center	★	★★	D	$404,816	$0
Memorial Care Long Beach Medical Center	★★	★★★	C	$207,276	$62,183
Memorial Care Miller Children's and Women's Hospital	★★	★★★	C	$ –	$ –
Memorial Care Orange Coast Medical Center	★★★★	★★★	C	$1,120,696	$672,418
Memorial Care Saddleback Medical Center	★★★	★★★	B	$412,305	$226,768
Orange County Global Medical Center	★	★★	D	$2,013,149	$0
Placentia Linda Hospital	★★	★★★	C	$360,336	$108,101
Pomona Valley Hospital Medical Center	★★★★	★★★	A	$29,354	$20,548
Providence Mission Hospital	★★★★	★★★	B	$1,305,806	$848,774
Providence St. Joseph Hospital	★★★★	★★★★	B	$2,881,640	$2,161,230
Providence St. Jude Medical Center	★★★★	★★★	B	$1,355,978	$881,386
South Coast Global Medical Center	N/A	★	D	$359,887	$0
UCI Medical Center	★★★★	★★★★	A	$5,881,296	$4,705,037
Whittier Hospital Medical Center	★★★	★★	B	$53,167	$18,608
	TOTALS			**$27,843,225**	**$15,391,218**

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/7/2025	**Initiative Name:**	OneCare Member Health Incentives	**Start Date:**	1/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2024
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$500,000
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Provide health rewards and incentives to motivate members to establish primary care relationships and get recommended preventive care and screenings.	From October to December 2024, CalOptima Health issued 8,758 member incentives to OneCare members, equating to $298,100. Annual wellness visits (3034 rewards, $151,700); Breast Cancer Screening (240 rewards, $6,000); Colorectal Cancer Screening (132 rewards, $6,600); Diabetes HbA1c test (300 rewards, $7,500); Diabetes Retinal Eye Exam (242 rewards, $6,050); Osteoporosis Screening (72 rewards; $1,800); and Health Risk Assessments (4,738 rewards, $118,450). Starting in 2025,CalOptima Health will reward OneCare gift cards digitally to expedite member receipt of incentives.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve rate of preventive health screenings	Breast cancer screening Colorectal cancer screening Osteoporosis management for people with fractures	Q2 data in progress available in July 2025
Improve screening rates for members with diabetes	Diabetes care: Blood sugar screening Retinal eye exams	Q2 data in progress available in July 2025

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/7/2025	**Initiative Name:**	Quality Initiatives from Unearned P4V Program	**Start Date:**	7/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2025
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$23.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health implements an annual Pay for Value Program (P4V) to promote high quality outcomes and improvement in quality measures among Health Network and CalOptima Health Care Network (CCN) primary care physicians (PCPs). Each year providers earn a portion of allocated incentive dollars and forfeit a portion of incentive dollars by not achieving the highest benchmarks. Starting with the measurement year 2023 P4V program, the Board approved the use of unearned incentive dollars towards quality initiatives.	- CalOptima Health finalized grant contracts for the 32 approved Medi-Cal grant projects. - Medi-Cal grant incentive checks were issued in December 2024/January 2025. - OneCare grant contracts are in process.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Stimulate improvement on lower performing quality measures by issuing grants to Health Networks and CCN PCPs for the implementation of quality improvement initiatives	Number of grant awards among Health Networks for Medi-Cal measures	17 grants were awarded to five Health Networks; totaling $2,940,120
	Number of grant awards among CCN PCPs for Medi-Cal measures	15 grants were awarded across 12 organizations totaling $2,052,492
	Number of grant awards among Health Networks for OneCare measures	5 grants were awarded to five Health Networks; totaling $1,028,628
Number of grant awards among CCN PCPs for Medi-Cal measures	(attachment)	

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Medi-Cal Quality Initiatives

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1			CCN		HPN-Regal		OPTUM		Prospect		Family Choice		CHOC		AMVI Care		Noble		AltaMed		UCMG	
2	Clinical Measure (HEDIS)	Submeasure	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
3	Breast Cancer Screening (BCS-E)	Non-MCR Total	58.47%	67th	58.45%	67th	51.28%	33rd	59.32%	67th	59.58%	67th	0.00%	<10th	66.52%	90th	51.14%	33rd	53.90%	33rd	55.08%	67th
4	Cervical Cancer Screening (CCS)		61.30%	67th	50.75%	10th	53.15%	10th	55.88%	33rd	61.20%	67th	4.31%	<10th	54.54%	33rd	46.03%	10th	57.85%	33rd	53.74%	33rd
5	Child and Adolexcent Well-Care Visits (WCV)	Total	47.07%	33rd	32.35%	<10th	47.69%	33rd	43.45%	10th	53.05%	67th	59.44%	67th	55.25%	67th	46.85%	33rd	41.17%	10th	51.98%	67th
6	Childhood Immunization Status (CIS)	Combo 10	29.60%	33rd	24.16%	10th	27.78%	33rd	41.08%	67th	45.58%	90th	35.64%	67th	34.98%	33rd	32.29%	33rd	41.64%	67th	57.93%	90th
7	Chlamydia Screening in Women (CHL)	Total	72.56%	90th	67.38%	67th	64.16%	67th	67.90%	90th	67.75%	90th	79.93%	90th	83.10%	90th	64.36%	67th	78.93%	90th	64.14%	67th
8	Controlling High Blood Pressure (CBP)		72.43%	90th	57.54%	10th	72.15%	67th	77.12%	90th	69.68%	67th	40.46%	<10th	93.52%	90th	84.12%	90th	82.01%	90th	61.54%	33rd
11	Hemoglobin A1c Control for Patients with Diabete	Poor Control	30.39%	67th	18.14%	90th	34.84%	33rd	37.56%	33rd	47.70%	10th	62.11%	<10th	12.81%	90th	26.50%	90th	27.00%	90th	18.12%	90th
12	Immunizations for Adolescents (IMA)	Combo 2	35.51%	33rd	23.92%	<10th	39.37%	67th	43.24%	67th	47.36%	67th	49.66%	90th	56.27%	90th	45.34%	67th	48.23%	67th	48.74%	67th
13	Lead Screening in Children (LSC)		62.71%	33rd	15.38%	<10th	55.93%	33rd	68.57%	67th	67.89%		64.75%	33rd	64.41%	33rd	64.74%	33rd	78.32%	67th	66.15%	33rd
14	Prenatal and Postpartum Care (PPC)	Postpartum	83.55%	67th	77.82%	33rd	72.62%	10th	53.04%	<10th	70.44%	10th	79.94%	33rd	70.05%	10th	64.63%	<10th	81.20%	67th	74.46%	10th
15	Prenatal and Postpartum Care (PPC)	Prenatal	92.11%	90th	85.63%	33rd	82.22%	33rd	72.54%	<10th	64.20%	<10th	82.96%	33rd	83.58%	33rd	83.50%	33rd	89.23%	67th	58.12%	<10th
16	Well-Child Visits in the First 30 Months of Life (W3	First 15 Months	53.18%	10th	50.00%	10th	60.46%	33rd	67.44%	67th	49.32%	10th	56.50%	33rd	67.02%	67th	57.14%	33rd	64.04%	67th	55.36%	33rd
17	Well-Child Visits in the First 30 Months of Life (W3	15 Months - 30 Months	70.73%	67th	54.55%	<10th	72.26%	67th	74.75%	67th	79.92%	90th	73.13%	67th	68.91%	33rd	71.25%	67th	57.89%	10th	73.86%	67th
18	Satifaction Measure (CAHPS)		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
19	Adult Care Coordination (Usually + Always)		84.62%	33rd	69.77%	<10th	82.14%	10th	88.89%	67th	80.00%	10th	81.25%	10th	72.73%	<10th	78.57%	10th	83.72%	33rd	71.05%	<10th
20	Adult Customer Service (Usually + Always)		85.71%	10th	83.79%	<10th	92.22%	90th	80.57%	<10th	83.02%	<10th	78.57%	<10th	81.82%	<10th	89.95%	33rd	90.16%	33rd	84.41%	<10th
21	Adult Getting Care Quickly (Usually + Always)		79.62%	33rd	81.79%	33rd	73.12%	<10th	76.94%	10th	72.88%	<10th	73.46%	10th	66.95%	<10th	75.29%	10th	73.95%	10th	73.51%	10th
22	Adult Getting Needed Care (Usually + Always)		80.96%	33rd	80.68%	33rd	75.49%	10th	77.80%	10th	73.13%	<10th	76.42%	10th	67.69%	<10th	81.30%	33rd	81.53%	33rd	72.31%	<10th
23	Adult Rating of Health Care (9+10)		67.71%	90th	55.29%	33rd	40.91%	<10th	44.55%	<10th	53.41%	10th	56.25%	33rd	50.88%	10th	52.54%	10th	63.86%	90th	44.93%	<10th
24	Adult Rating of Health Network (9+10)		59.17%	10th	53.69%	10th	52.08%	<10th	59.56%	33rd	53.08%	10th	68.92%	90th	50.66%	<10th	59.29%	10th	60.84%	33rd	50.61%	<10th
25	Adult Rating of PCP (9+10)		75.81%	90th	63.71%	10th	66.34%	33rd	65.38%	33rd	60.51%	<10th	83.67%	90th	59.62%	<10th	77.33%	90th	68.13%	33rd	64.91%	10th
26	Adult Rating of Specialist (9+10)		62.32%	10th	63.64%	10th	59.26%	<10th	59.74%	<10th	59.04%	<10th	55.56%	<10th	60.38%	<10th	72.73%	90th	76.47%	90th	51.67%	<10th
27	CAHPS Measure		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
28	Child Care Coordination (Usually + Always)		71.43%	<10th	90.00%	90th	80.77%	10th	78.57%	10th	72.00%	<10th	71.88%	<10th	60.00%	<10th	77.27%	10th	90.48%	90th	70.97%	<10th
29	Child Customer Service (Usually + Always)		86.49%	10th	89.29%	33rd	90.70%	67th	81.62%	<10th	75.00%	<10th	86.27%	10th	78.95%	<10th	89.19%	67th	87.50%	33rd	78.68%	<10th
30	Child Getting Care Quickly (Usually + Always)		75.82%	<10th	90.91%	90th	79.95%	10th	80.22%	10th	81.05%	10th	87.10%	33rd	79.41%	10th	75.75%	<10th	87.50%	33rd	81.46%	10th
31	Child Getting Needed Care (Usually + Always)		72.33%	<10th	78.24%	10th	68.45%	<10th	79.37%	10th	68.14%	<10th	75.70%	10th	71.57%	<10th	74.60%	<10th	84.45%	33rd	68.94%	<10th
32	Child Rating of Health Care (9+10)		50.00%	<10th	50.00%	10th	62.64%	10th	61.11%	<10th	53.85%	<10th	55.13%	<10th	47.62%	<10th	58.90%	<10th	59.68%	<10th	65.42%	10th
33	Child Rating of Health Network (9+10)		55.48%	<10th	59.65%	33rd	67.50%	10th	59.49%	<10th	54.05%	<10th	68.00%	10th	43.44%	<10th	65.66%	10th	68.64%	10th	52.63%	<10th
34	Child Rating of PCP (9+10)		70.69%	10th	63.41%	10th	72.00%	10th	60.95%	<10th	59.35%	<10th	70.34%	<10th	55.13%	<10th	75.00%	33rd	77.78%	33rd	69.74%	<10th
35	Child Rating of Specialist (9+10)		71.43%	33rd	62.50%	10th	77.78%	90th	72.41%	33rd	60.71%	<10th	76.47%	67th	57.89%	<10th	71.43%	33rd	76.92%	67th	52.94%	<10th

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OneCare Quality Initiatives

OneCare HEDIS Part C Measure	Submeasure	CCN		HPN-Regal		OPTUM		Prospect		AMVI Care		Family Choice		AltaMed		Noble		UCMG	
		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
Breast Cancer Screening (BCS-E)	MCR Total	62.64%	2Star	60.87%	2Star	68.13%	3Star	70.94%	3Star	78.00%	4Star	0.6119	2Star	76.00%	4Star	65.91%	3Star	61.78%	2Star
Colorectal Cancer Screening (COL)	50-75 years old	65.59%	3Star	75.07%	4Star	69.71%	3Star	67.27%	3Star	63.19%	3Star	0.7123	4Star	69.26%	3Star	66.70%	3Star	72.89%	4Star
Eye Exam for Patients with Diabetes (EED)	Total	73.93%	4Star	85.30%	5Star	79.04%	4Star	73.70%	4Star	85.93%	5Star	0.738	4Star	59.59%	2Star	78.57%	4Star	71.68%	3Star
Controlling High Blood Pressure (CBP)		65.84%	2Star	85.61%	5Star	75.68%	4Star	81.53%	4Star	85.40%	5Star	0.6718	2Star	83.20%	5Star	73.79%	3Star	71.72%	3Star
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Poor Control	14.38%	4Star	0.00%	5Star	20.57%	3Star	27.34%	3Star	0.00%	5Star	0.0054	5Star	0.00%	5Star	34.23%	2Star	0.00%	5Star
CAHPS Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Adult Care Coordination (Usually + Always)		86.11%	4Star	89.86%	5Star	87.09%	5Star	87.06%	5Star	83.68%	2Star	87.58%	5Star	86.38%	4Star	86.29%	4Star	86.70%	4Star
Adult Getting Care Quickly (Usually + Always)		74.68%	2Star	75.16%	2Star	78.48%	4Star	74.72%	2Star	74.56%	2Star	76.26%	3Star	74.77%	2Star	72.08%	1Star	78.19%	4Star
Adult Getting Needed Care (Usually + Always)		81.76%	4Star	86.34%	5Star	81.54%	4Star	82.99%	4Star	78.55%	3Star	79.86%	3Star	87.15%	5Star	87.50%	5Star	78.03%	3Star
Part D Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Medication Adherence for Diabetes Medications (D08)		84.71%	3Star	84.40%	3Star	87.20%	3Star	84.98%	3Star	87.32%	3Star	91.08%	5Star	81.59%	2Star	73.24%	1Star	94.20%	5Star
Medication Adherence for Hypertension (D09)		84.38%	2Star	76.38%	1Star	86.71%	3Star	86.14%	3Star	89.56%	4Star	88.47%	3Star	81.58%	1Star	83.05%	2Star	91.15%	5Star
Medication Adherence for Cholesterol (D10)		83.96%	2Star	82.55%	2Star	82.27%	2Star	83.43%	2Star	83.43%	2Star	86.48%	3Star	79.10%	1Star	79.98%	1Star	86.30%	3Star
Statin Use in Persons with Diabetes (D12)		84.40%	2Star	89.96%	4Star	85.66%	2Star	87.31%	3Star	96.28%	5Star	92.50%	5Star	89.18%	4Star	91.62%	4Star	91.76%	4Star

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/10/2025	**Initiative Name:**	Digital Transformation Strategy	**Start Date:**	2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$100.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Digital Transformation Strategy to enhance overall experience for members, providers, and employees by bridging technology and business areas, improving member and provider experience, operational effectiveness, and financial performance.	Internet and network bandwidth upgrades completed in December 2024. This increase was vital to a cloud first architecture. The Salesforce implementation for Provider Life Cycle Management is being adjusted to meet credentialing benchmarks. The Salesforce Call Center CRM project is on track and leadership is assessing possibly implementing this 2-3 months faster than planned. Refer to supplemental page for funding information.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve Member & Provider Experience by providing an improved digital experience	% of completion of member and provider requests through self service digital tools	TBD - metrics development in progress
Complete Digital Transformation projects on-time and within budget	95% of projects delivered on-time and within budget	6 projects have been completed on-time and within budget, representing 20% of the total planned projects. 30 total projects, 10 In-Flight, 12 to be started.

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CalOptima Health

Digital Transformation Projects: Status Report

Project Title	Status	Current Annual Budget	Actual Spend
Provider Lifecycle Management (Salesforce)	In Progress	$4,100,000	$ 1,040,000
Jiva Platform Implementation	In Progress	$3,950,000	$ 1,313,197
WebMD Ignite (FKA Healthwise) Implementation	In Progress	$0	$ 0
Jiva Findhelp Integration	In Progress	$50,000	$ 45,000
Content Management for Websites	In Progress	$2,457,100	$ 1,020,938
Contract Center Telephony System Replacement (NICE)	In Progress	$2,383,000	$ 295,482
Call Center CRM (Salesforce)	In Progress	$2,231,250	$ 0
Finance ERP - Crowe MS Dynamics	In Progress	$1,706,000	$ 108,000
Enterprise RPA	In Progress	$1,500,000	$ 1,132,473
HCM & Payroll - ADP Solution	In Progress	$450,000	$ 18,170
Internet Bandwidth Upgrade for All Sites	Closed	$603,323	$ 603,323
Network Bandwidth Upgrade for All Sites - Wide Area Network	Closed	$3,631,487	$ 3,631,487
Cohesity	Closed	$283,489	$ 283,489
Verisys Credentialing Verification	Closed	$105,000	$ 105,000
Digital Transformation Strategy (includes Strategic Governance)	Closed	$1,408,060	$ 1,434,655
SSRS to Power Migration (Phase 1)	Closed	$325,500	$ 183,300
Member Portal and App	New	$2,000,000	$ 0
CMS Member Pref. & Consent Mgmt. for Data Sharing	New	$75,000	$ 0
Web Traffic Analytics for Websites and Portals	New	$50,000	$ 0
Migration off SecureAuth	New	$56,500	$ 0
Web Based Services for Facets	New	$250,000	$ 184,4910
Network Operations Center Monitoring and Control System	New	$300,000	$ 0
Automate Computer Provision Management Resources with New Infrastructure as a Code (IaC) Technology	New	$185,000	$ 0
Website Auditing Tool	New	$25,000	$ 0
Data Strategy, Governance, and Execution	New	$2,975,000	$ 40,0000
File Encryption	New	$200,000	$ 0
RightFax Transition to the Cloud	New	$150,000	$ 21,956
MCG Auto Auth	New	$125,000	$ 0

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	2/24/2025	**Initiative Name:**	Medi-Cal Provider Rate Increases	**Start Date:**	7/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$526.2 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Authorize the CEO to execute amendments to delegated Health Networks and specific CalOptima Health Medi-Cal FFS CCN/COD contracts that update contracted rates, effective 7/1/2024, and incorporate requirements to comply with DHCS mandated Targeted Rate Increases (TRI) and other regulatory and operational requirements, effective 1/1/2024. This initiative aims to improve quality outcomes through increased access, increased provider and member satisfaction (i.e. CAHPS measures), and decreased provider terminations due to non-market competitive rates.	1) Executed contracted amendments to implement rate increases. 2) Analyze tracking reports for network additions and terminations to compare network changes prior to and after 7/01/2024. 3) Obtain results of the 2024 Timely Access Survey and CAHPs results to analyze and determine if the initiative achieved the expected results.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Maintain and increase members' access to care.	Maintain and enhance network adequacy.	1) Added a provider network summary to CalOptima Health Fast Facts published monthly in the CalOptima Health Board Book. 2) Presented network adequacy deficiencies at the Q3 Quality Assurance Committee of the Board.
	Increase timely access to care for members.	Presented 2023 Timely Access Survey at the Q3 Quality Assurance Committee of the Board.
Maintain and increase quality of care for members.	Increase quality scores through the 2024 HEDIS and Quality Scores.	TBD: 2024 HEDIS and quality scores to be released in Q3, 2025.
Improve provider satisfaction.	Increase provider satisfaction scores.	Provider survey response rates too low to produce statistically significant results. Next step will be to engage a vendor to design and administer a provider satisfaction survey using multiple modalities in effort to increase response rates and achieve statistically significant and actionable results.

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Board-Approved Initiative Status and Impact Summary

Report Date:	2/13/2025	**Initiative Name:**	Skilled Nursing Facility Access Program	**Start Date:**	1/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$10.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Skilled Nursing Facility (SNF) Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care.	- Identified 4 categories of difficult to place members and provided additional incentives for accepting members. - No funds have been utilized at this time; continuing to identify opportunities to expand on program requiring resource support. Started a SNF workgroup to review the DHCS APL 25-002 Workforce Quality Incentive Program based on AB-186 to improve quality of care and incentive payments. - Next steps: 1) Implement clinical SNF rounds 2) Create a preferred SNF network 3) Partner with dialysis provider (Fresinius) for mobile units

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve acceptance rate for TOC patients from acute setting to SNF	Reduced administrative days by 5%	In development; data analysis in progress.
Establish clinical rounds at SNFs by Q2 2025 (CY)	Established clinical rounds with SNF providers	Establishing clinical rounds at 3 largest identified SNF providers.
Establish partnership meetings with contracted SNFs	Established partnership meetings	Met with ExamMed and Medrinas and identified 8 SNFs that house custodial members.
Improve provider payments for difficult-to-place members	Rate enhancement for members w/ isolation, bedside dialysis, social and behavioral obesity	Implemented; enhanced rates effective July 2024 through Medi-Cal Provider Rate Increase

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Authorize Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

Contacts

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

Recommended Actions

1. Authorize modification of the previously Board-approved Student Behavioral Health Incentive Program (SBHIP) Incentive Funding Plan to support SBHIP Phase Two:
    a. Reallocate to Hazel Health up to $3.5 million from the Notice of Funding Opportunity (grants to serve Medi-Cal school-aged children and youth in Orange County).
    b. Allocate up to $471,000 in unallocated funding:
        i. Up to $371,000 for the internal Contracting Program Support Position to manage the contracting activities supporting SBHIP.
        ii. Up to $100,000 for the California School-Based Health Alliance, 2025 School Health Conference sponsorship.
2. Authorize the Chief Executive Officer, or designee, to amend the Memorandum of Understanding with Hazel Health to extend the end date to June 30, 2026.
3. Approve expenditures of up to $100,000 and staff participation at the 2025 School Health Conference on April 28-29, 2025, in Anaheim;
    a. Make a finding that such an expenditure is for a public purpose and in furtherance of CalOptima Health′s mission and statutory purpose; and
    b. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

The SBHIP is a Department of Health Care Services (DHCS) 3-year state initiative. The Board of Directors (Board) approved three previous actions related to SBHIP. On December 20, 2021, the Board authorized the Chief Executive Officer (CEO) to submit a letter of intent to DHCS by January 31, 2022, for CalOptima Health's intent to participate in the 3-year SBHIP. On August 4, 2022, the Board authorized the CEO, with the assistance of legal counsel, to execute memorandums of understanding and contracts with SBHIP grantees. On May 4, 2023, the Board authorized the CEO to allocate and distribute the SBHIP incentive payment funds to the SBHIP partners Hazel Health, Western Youth Services (WYS), Children's Hospital of Orange County (CHOC), and Orange County Office of Education (OCDE) and its 29 Orange County Public School Districts.

Through the SBHIP, DHCS determined that CalOptima Health could receive incentive payments of up to $25,459,676. Since the program's inception, CalOptima Health and its SBHIP partners have been completing the expected SBHIP objectives and activities. As of this writing, approximately $22.3 million has been received, with the remaining $3.1 million anticipated this fiscal year.

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Discussion

Modification to SBHIP Incentive Funding Plan – Phase Two

As staff returns to the Board with a program update and recommendations on the remaining unallocated and unused SBHIP funds during the 3 years of SBHIP, per DHCS' directive, CalOptima Health and the SBHIP partners have continued to reassess the ongoing needs of the students. Staff proposes the following modification to the SBHIP Incentive Funding Plan to continue to support the collaborative partnerships and investments implemented during SBHIP. The changes to the funding plan do not cause an increase or decrease in the overall DHCS-determined eligible earnings of up to $25,459,676.

Entity	5/4/23 Board-approved SBHIP Funding	03/06/25 Proposed Board-action	Proposed Modified Funding
CHOC	Up to $2.1M	-	Up to $2.1M
WYS	Up to $802K	-	Up to $802K
OCDE and the 29 Orange County Public School Districts	Up to $10.0M	-	Up to $10.0M
Hazel Health	Up to $8.4M	Up to $3.5M	Up to $11.9M
CalOptima Health Program Support Positions	Up to $200K	Up to $371K	Up to $571K
Notice of Funding Opportunity (grants to serve Medi-Cal school-aged children and youth in Orange County)	Up to $3.5M	Remove	0
Remaining Unallocated Budget	Up to $471K	Allocate	0
California School-Based Health Alliance Sponsorship Event April 28-29, 2025	-	Up to $100K	Up to $100K
Total:	**$25.5M**	**$4.0M**	**$25.5M**

Hazel Health

The school districts and OCDE confirmed to staff the need to continue services through Hazel Health. This action will provide more time for school districts that have deployed Hazel Health to increase utilization of the services and time for the other districts to engage Hazel Health to activate telehealth services. Staff requests the Board reallocate to Hazel Health up to $3.5 million from grants to serve Medi-Cal school-aged children in Orange County in order for Hazel Health to continue providing telehealth services during the 2025-2026 school year. The reallocation will provide further time for analysis of utilization data to determine continuance of Hazel Health services after the 2025-2026 school year, and aligns with the SBHIP biquarterly reports already submitted to and approved by DHCS. To implement the extension, staff will pursue an amendment of the Hazel Health MOU to extend the end date to June 30, 2026.

California School-Based Health Alliance, 2025 School Health Conference

Staff received a request on September 6, 2024, inviting CalOptima Health to be the presenting sponsor of the 2025 School Health Conference - The Power of Partnerships to be held on April 28 & 29, 2025.

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The event is hosted by the California School-Based Health Alliance (CSHA), a statewide nonprofit organization that advances increased access to primary and behavioral health services for the state's public school students. Per CalOptima Health Policy AA.1223 - Participation in Community Events by External Entities, financial requests from qualified external entities for eligible events valued at more than $25,000 require Board approval. Since the request of a $100,000 allocation for sponsorship exceeds this amount, staff seek Board approval to participate.

This sponsorship will position CalOptima Health to support behavioral health services in Orange County schools and disseminate learnings of the SBHIP partnerships and achievements to attendees from schools in Orange County and around the state. CSHA began participating in CalOptima Health's SBHIP Provider convenings in the fall of 2024, leveraging their subject matter expertise and best practices in delivering high-quality, comprehensive school-based health care. CalOptima Health's sponsorship will provide an opportunity to model the valuable partnerships CalOptima Health built with Orange County stakeholders so the anticipated 800 attendees can learn and carry out similar work in their communities as they work to improve access to health and behavioral health services in schools. CalOptima Health will be provided with exclusive benefits as a presenting sponsor, including being prominently featured in all conference promotional materials, leading the Orange County regional breakout session with local stakeholders, and providing welcome remarks at the conference opening and reception.

Program Support Positions: Staff requests an allocation of up to $371,000 to continue to fund an internal Contracting Program Support Position to manage the contracting activities supporting SBHIP.

The following provides an update on the spending of the SBHIP Funding Plan as of December 31, 2024.

SBHIP Funding Update	Amount
Spend as of December 31, 2024	$15.4M
As of December 31, 2024, SBHIP allocated funds to be distributed to the SBHIP Partners	$6.1M
Unallocated/unused funds	$4.0M
Total:	**$25.5M**

Fiscal Impact

The recommended actions will be funded by a reallocation of up to $3.5 million and an allocation of up to $471,000 in SBHIP incentive payment funding and has no additional net fiscal impact.

Rationale for Recommendation

CalOptima Health recommends proceeding with the requested actions to continue SBHIP Phase Two activities supporting its continued commitment to youth behavioral health and wellness.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. SBHIP Update
2. CalOptima Health policy AA.1223 - Participation in Community Events by External Entities
3. Covered Entity

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4. 12/20/21 COBAR: Approve action related to the Student Behavioral Health Incentive Program
5. 08/04/22 COBAR: Approve action related to the Student Behavioral Health Incentive Program
6. 05/04/23 COBAR: Approve action related to the Student Behavioral Health Incentive Program Funding Strategy_Rev

/s/ Michael Hunn *02/28/2025*
Authorized Signature **Date**

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Attachment: SBHIP Update

OCDE and the 29 Orange County Public School Districts

- Increased the behavioral health school personnel/workforce by achieving the SBHIP 10-20% goal.
- 17 of the 29 public school districts have either: 1) expanded their use of universal screeners, 2) purchased and piloted the screener, or 3) renewed contracts with current screener publishers.
- Through SBHIP, many of the public-school districts made a significant improvement in their IT infrastructure/systems from previous manual processes to sophisticated systems. 27 of the 29 public-school districts reported progress towards utilizing electronic health record systems or exploring other systems for tracking and documentation.

CHOC

- SBHIP-funded WellSpaces:
  - Increased the number of WellSpaces in the Orange County public school districts by installing the 10 expected SBHIP-funded WellSpaces.
  - Overall, including the SBHIP-funded WellSpaces, the number of WellSpaces has significantly increased from 19 at the start of SBHIP to 54 at the close of the SBHIP program timeline.
- The School Reintegration Program:
  - A full-time licensed social worker was hired to support the school reintegration program launched in late 2023.
  - The program's purpose is to provide a service to help children reintegrate back into school after a mental health crisis, with family permission and help schools provide an optimal environment to support the child and family.
- The Mental Health Crisis Clinic (MHCC):
  - MHCC opened to community and schools in February 2024.
  - Students with identified suicidal ideation and no current therapist can be seen within 72 hours for an initial evaluation by a mental health clinician and up to three (3) additional stabilization sessions while awaiting connection to long term community services.
- The Deaf or Hard-of-Hearing Consultative Services:
  - In late 2023, CHOC hired a deaf and hard of hearing psychologist for the program, who provides consultative support at no cost to the public-school districts.
  - The psychologist's consultative service identifies mental health needs and shares best practices for deaf and hard of hearing students, ensuring equitable care for this student population.
- The Autism Comprehensive Care Program:
  - Projected to start by 2nd quarter 2025.
  - The pilot program plans to serve students between the ages of 12-17 with Autism and acute/severe mental health concerns such as depression, suicidal ideation,

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anxiety, etc.

Western Youth Services (WYS)

- In August 2024, WYS deployed an on-demand virtual Behavioral Health Curriculum library for the 29 Orange County public school districts
- Also, WYS is conducting in-person trainings and post-training consultative support.

Hazel Health (telehealth counseling services)

- Launched in January 2024, 19 of the 29 public school districts implemented Hazel Health in 340 of the 586 public schools, which account for 260,121 students who now have access to Hazel Health.
- The counseling services are delivered on school sites or in the student's home.

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	Communications
Section:	Community Relations
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	02/02/2017
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for CalOptima Health's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima Health's Participation in community events involving external entities, financially, or otherwise, shall be approved only if aligned with CalOptima Health's mission, vision and values.

B. An external entity may be eligible for CalOptima Health's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima Health members or supports CalOptima Health's mission, vision and values. Religious organizations are not eligible for CalOptima Health's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima Health's funds shall only be made for a direct and primary public purpose within CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima Health's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima Health's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;

2. A presentation, or panel presentation, by a CalOptima Health representative;

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3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members and/or potential members who could be enrolled in any of CalOptima Health's programs; or

4. Other opportunity to promote CalOptima Health's services and increase awareness about CalOptima Health.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way), may be permitted based on a finding by the CalOptima Health Board of Directors that the request for financial Participation falls within CalOptima Health's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides; or

2. There is an identifiable benefit to CalOptima Health and/or its members.

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima Health in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima Health's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of twenty-five thousand dollars ($25,000) per organization per fiscal year, which shall include all materials and supplies:

    a. Requests for financial Participation in an amount up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.

    b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year, subject to availability of budgeted funds.

    c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

        i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

        ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

    d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

    e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than twenty-five thousand dollars ($25,000) per organization per fiscal year:

    a. Requests for financial Participation for the amount of more than twenty-five thousand dollars ($25,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

    b. Financial requests from qualified external entities for eligible events valued at more than twenty-five thousand dollars ($25,000) require approval from the CalOptima Health Board of Directors and a finding that such financial Participation is in the public good, subject to

availability of budgeted funds, and within CalOptima Health's authority and statutory purpose.

c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's program, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than twenty-five thousand dollars ($25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima Health's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima Health staff time (*e.g.*, in their capacity as a CalOptima Health employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima Health resources (*e.g.*, CalOptima Health facilities);

c. The use of current, or future, CalOptima Health eligible funds; and

d. The value of items donated with the CalOptima Health master brand/logo.

H. In no event shall approval of CalOptima Health's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima Health's name, or logo, in any material by an external entity shall be governed by CalOptima Health Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima Health's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Health Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO or his/her designee shall provide members of the CalOptima Health Board of Directors with advanced notice, so they have the opportunity to attend events in which CalOptima Health participates.

L. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima Health, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

M. In the event CalOptima Health's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima Health's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima Health's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima Health's Community Relations Department shall:

1. Notify the requesting entity of CalOptima Health's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:

1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Health Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Health Public Activity Participation Request Form
B. CalOptima Health Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Health Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support, and Use of CalOptima Health Name or Logo
D. CalOptima Health Policy GA.5004: Travel Policy
E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2022	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2023	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2024	AA.1223	Participation in Community Events by External Entities	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima Health.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose.

Attachment to March 6, 2025 Board of Directors Meeting – Agenda Item 13

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
California School-Based Health Alliance	1203 Preservation Park Way, Suite 302	Oakland	CA	94612

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Consent Calendar
20. Consider Approval of Action Related to the Student Behavioral Health Incentive Program

Contacts
Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Natalie Zavala, Interim Director, Behavioral Health Integration, (657) 900-1339

Recommended Action
Authorize the Chief Executive Officer to send a Letter of Intent (LOI) by January 31, 2022, to notify the California Department of Health Care Services (DHCS) of CalOptima's intent to participate in the three -year Student Behavioral Health Incentive Program (SBHIP).

Background/Discussion
The Fiscal Year 2021–22 Enacted State Budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim to improve the behavioral health system for youth (ages 0 to 25). One component of the CYBHI is the SBHIP, through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide. As defined in Assembly Bill (AB) 133, the intent is to establish and build infrastructure, partnerships and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Incentive payments are not intended to pay for behavioral health treatment services but rather to increase access to services and the number of children receiving services. The current behavioral health Medi-Cal delivery system already allows for reimbursement of such services.

The State recognizes the behavioral health crisis our youth are facing across the nation. Mental health hospitalizations, suicide rates and overdose deaths have increased in our youth over the past decade. The public health emergency stay-at-home orders and school closures have caused further impact. Youth and adolescents have suffered from isolation and chronic stress which are correlated with higher rates of mental illness and substance use disorders. Schools are considered critical points of access for prevention and early intervention services and provide an opportunity to address disparities. This program aims to address potential gaps in access and increase the number of youth receiving behavioral health services.

In order to participate in the SBHIP, CalOptima is required to notify DHCS of its intent to participate in the program no later than January 31, 2022. As such, staff is seeking authorization for the CEO to submit an LOI to DHCS. The provisions of AB 133 related to the Medi-Cal MCP incentive payments are attached. As additional details from DHCS on participation and implementation become available, staff will provide them to the Board and shall return to the Board for further action as necessary, such as amendment to the State Contract to include the incentive program.

Back to Agenda Back to Item

Fiscal Impact

The recommended action to provide DHCS with a commitment letter has no fiscal impact. Staff anticipates funding for the new SBHIP program will be sufficient to fully cover the expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation

Providing the recommended LOI notifies DHCS of CalOptima's intent to participate in the SBHIP.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

5961.3.

(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Approve Action Related to the Student Behavioral Health Incentive Program

Contact
Carmen Katsarov LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Actions
1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandums of Understanding (MOUs) and contracts with School Behavioral Health Incentive Program (SBHIP) grantee(s) upon selection and approval by the Department of Health Care Services (DHCS).

Background
The fiscal year 2021–22 enacted state budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim of improving the behavioral health system for youth (ages 0 to 25).

One component of the CYBHI is the School Behavioral Health Incentive Program (SBHIP) through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide.

The intent of SBHIP is to establish and build infrastructure, partnerships, and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Please refer to Attachment 1 for additional information that was presented to the Board in December 2021.

Updates

- On March 15, 2022, CalOptima submitted to DHCS the SBHIP partners form with the Orange County Department of Education (OCDE) superintendent, Dr. Al Mijares, identifying the three school districts (Santa Ana Unified, Garden Grove Unified, and Anaheim Unified) that initially confirmed interest in participating in SBHIP.
- CalOptima collaborated with Orange County Health Care Agency (OC HCA) for increased collaboration with Orange County superintendents for SBHIP. CalOptima's Executive Director, Behavioral Health Integration, is now attending the weekly superintendent mental health work group. This increased collaboration effort resulted in 17 school districts confirming interest in participating in SBHIP as of June 2022. *See* Attachment 2.
- CalOptima received 50% of the allotted needs assessment funds in the amount of $217,500 from DHCS on June 14, 2022.

Discussion
CalOptima is currently working on the DHCS deliverables below with OCDE, LEAs' school superintendents, and OC HCA. The MOU is an important part of the implementation plan for SBHIP. *See* Attachment 3.

DHCS SBHIP Timeline and Deliverables	DHCS Due Date	Status/ Start Date
Board Approval for Letter of Intent (LOI)	12/20/21	Completed
Submit LOI to DHCS	1/31/22	Completed
Partners Form Due to DHCS (Milestone One)	3/15/22	Completed
Medi-Cal MCPs and selected partners conduct assessment	2nd/3rd Quarter 2022	In Progress
Select targeted intervention(s) and submit project plan (Milestone One) to DHCS	12/31/22	August 2022

Once CalOptima collects more data and receives additional guidance from DHCS, staff will return to the Board with a plan for distributing funds to the school districts.

Fiscal Impact
Staff anticipates funding for the new SBHIP program to be sufficient to fully cover expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation
Staff recommends that the Board approve the recommended action so CalOptima can continue to meet all regulatory timelines and DHCS deliverables related to SBHIP. Participation in SBHIP will contribute toward CalOptima's overall goal, in partnership with the OC HCA, of creating a comprehensive and sustainable continuous system of care for all students to access the entire scope of available mental health benefits and services in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. December 15, 2021, previous COBAR for approval of LOI with AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions
2. List of participating LEAs
3. SBHIP MOU Template Draft

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Approved	N/A	N/A

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Consent Calendar
20. Consider Approval of Action Related to the Student Behavioral Health Incentive Program

Contacts
Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Natalie Zavala, Interim Director, Behavioral Health Integration, (657) 900-1339

Recommended Action
Authorize the Chief Executive Officer to send a Letter of Intent (LOI) by January 31, 2022, to notify the California Department of Health Care Services (DHCS) of CalOptima's intent to participate in the three -year Student Behavioral Health Incentive Program (SBHIP).

Background/Discussion
The Fiscal Year 2021–22 Enacted State Budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim to improve the behavioral health system for youth (ages 0 to 25). One component of the CYBHI is the SBHIP, through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide. As defined in Assembly Bill (AB) 133, the intent is to establish and build infrastructure, partnerships and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Incentive payments are not intended to pay for behavioral health treatment services but rather to increase access to services and the number of children receiving services. The current behavioral health Medi-Cal delivery system already allows for reimbursement of such services.

The State recognizes the behavioral health crisis our youth are facing across the nation. Mental health hospitalizations, suicide rates and overdose deaths have increased in our youth over the past decade. The public health emergency stay-at-home orders and school closures have caused further impact. Youth and adolescents have suffered from isolation and chronic stress which are correlated with higher rates of mental illness and substance use disorders. Schools are considered critical points of access for prevention and early intervention services and provide an opportunity to address disparities. This program aims to address potential gaps in access and increase the number of youth receiving behavioral health services.

In order to participate in the SBHIP, CalOptima is required to notify DHCS of its intent to participate in the program no later than January 31, 2022. As such, staff is seeking authorization for the CEO to submit an LOI to DHCS. The provisions of AB 133 related to the Medi-Cal MCP incentive payments are attached. As additional details from DHCS on participation and implementation become available, staff will provide them to the Board and shall return to the Board for further action as necessary, such as amendment to the State Contract to include the incentive program.

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Fiscal Impact

The recommended action to provide DHCS with a commitment letter has no fiscal impact. Staff anticipates funding for the new SBHIP program will be sufficient to fully cover the expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation

Providing the recommended LOI notifies DHCS of CalOptima's intent to participate in the SBHIP.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

5961.3.

(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

K-12 School Districts	Partner with CalOptima for SBHIP	School Contact
1. Anaheim Elementary	Yes	Shirley Diaz
2. Anaheim Union High	Yes	Dr. Adela Cruz, LCSW
3. Brea Olinda Unified	Yes	Cherry Lee, NCSP. BCBA
4. Buena Park	Yes	Elsie Briseño Simonovski, Ph.D
5. Centralia Elementary	Yes	Michelle Castillo/ Stacy Chang
6. Cypress	Yes	Tandy Taylor
7. Fullerton Joint Union High	Yes	Carlos Alcántara, LCSW, PPSC
8. Garden Grove Unified	Yes	Jeffrey Layland, Ed.D.
9. Huntington Beach City	Yes	Megan Kempner
10. Laguna Beach Unified	Yes	Michael Keller
11. Los Alamitos Unified	Yes	Grace Delk
12. Lowell Joint	Yes	Sheri McDonald, Ed.D.
13. Magnolia	Yes	Wendy Castillo
14. Orange Unified	Yes	Kristen Nelson, M.A.
15. Santa Ana Unified	Yes	Sonia Llamas, Ed.D
16. Savanna	Yes	Hipolito Murillo
17. Tustin Unified	Yes	Monique Yessian

MEMORANDUM OF UNDERSTANDING
BETWEEN

_____

AND
ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA
FOR STUDENT BEHAVIORAL HEALTH INCENTIVE PROGRAM

This Memorandum of Understanding ("**MOU**") is made and entered into as of this ___ day of ____, 2023 ("**Effective Date**"), by and between [insert legal name here] ("**School District**") and Orange County Health Authority dba CalOptima ("**CalOptima**") in order to facilitate successful implementation of School District's Student Behavioral Health Incentive Program ("**SBHIP**"). School District and CalOptima may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. In accordance with California Welfare & Institutions Code Section 5961.3, the California Department of Health Care Services ("DHCS") designed and implemented the SBHIP to increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in public schools;

B. DHCS established a process, in partnership with Medi-Cal managed care plans ("MCPs") and eligible Orange County school districts, for MCPs to oversee and administer payment for approved SBHIP intervention implementation plan(s);

C. CalOptima, as an MCP participating in the SBHIP, has selected School District's intervention implementation plan(s) ("**Plan**") for the SBHIP; and

D. CalOptima is responsible for oversight and administration of payments to School District consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any DHCS guidance related to the SBHIP.

AGREEMENT

Therefore, CalOptima and School District agree as follows:

1. **Term**. The Term of this MOU shall begin on the Effective Date and shall terminate on [insert termination date], unless earlier terminated under Section 2.

2. **Termination**. The terms of this MOU are contingent upon the approval of School District's SBHIP intervention implementation plan(s), the availability of sufficient state and federal Medicaid funding, and all necessary federal approvals to be obtained by DHCS. Should sufficient funds not be allocated, federal financial participation be unavailable, or DHCS not obtain the necessary approvals, CalOptima may modify the services under the MOU accordingly upon written notice to School District or terminate this MOU after giving School District thirty (30) days' prior written notice. CalOptima

may also terminate this MOU with thirty (30) days' prior written notice to School District and DHCS if School District (i) breaches a material term of the MOU and fails to correct the breach within the thirty (30)-day notice period, or (ii) fails to meet terms of a corrective action plan ("**CAP**"), as set forth in Section 5.

3. **Scope of Project.** School District is responsible for the implementation of and compliance with the SBHIP, as set forth in Plan, which is attached to this MOU as Exhibit 1 and incorporated into the MOU by this reference. School District's compliance includes reporting to CalOptima on the achievement of milestones and objectives consistent with the terms of the SBHIP and the Plan. School District shall promptly notify CalOptima of any material change in information submitted in support of the SBHIP or the Plan, including changes in organizational leadership, business operations, and financial standing. CalOptima is responsible for overseeing the SBHIP as it relates to School District, including monitoring and verifying milestone achievements and administering payments consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any subsequent DHCS guidance related to the SBHIP.

4. **Confidentiality.** CalOptima and School District's performance under this MOU may require the exchange of confidential and/or proprietary information ("**Confidential Information**") as may be identified by either Party. Confidential Information includes but is not limited to computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and proprietary or other information, materials, records, writings, or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Each Party agrees to protect the other Party's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care. The Parties also shall comply with the processes, standards, and other requirements applicable to the exchange of either Party's respective Confidential Information, in accordance with applicable state and federal law.

5. **Corrective Action**. Upon written notice to School District, CalOptima may implement a CAP for School District or other DHCS-required mechanism (i) to modify the MOU requirements, (ii) to facilitate School District's compliance with the MOU and SBHIP terms, or (iii) to adjust SBHIP/Plan goals and objectives and related payments, as necessary. Such modifications are subject to DHCS review and approval. School District's noncompliance with modifications under this Section 5 may result in CalOptima's termination of this MOU under Section 2. In the event of MOU termination under Section 2, School District shall return funds distributed to School District under this MOU as directed by CalOptima.

6. **School District Responsibilities**.

   A. Use of Funding.

i. School District shall only expend funds provided to School District by CalOptima under this MOU for the purposes of carrying out activities and achieving milestones set forth in this MOU and the Plan.

ii. School District shall document to CalOptima, in a form and manner determined by CalOptima, that Plan activities have been carried out and milestones have been achieved under this MOU.

iii. If School District does not carry out Plan activities and achieve Plan milestones, School District shall promptly notify CalOptima and return any funds that School District received related to those unperformed activities or unachieved milestones under the Plan.

B. Practice Redesign and Infrastructure Development Reporting.

i. School District shall timely implement the practice redesign and infrastructure development components set forth in and in accordance with the terms of the Plan.

ii. School District shall regularly report to CalOptima on the progress of the practice redesign and infrastructure development on a schedule in a format and process specified in the Plan or as otherwise agreed in writing between the Parties.

C. Milestone Achievement.

i. School District shall perform all tasks necessary to meet milestones required by the Plan. School District shall provide CalOptima with the information necessary for CalOptima to determine School District's progress in achieving the milestones set forth in the Plan.

D. Measure Reporting.

i. School District will report to CalOptima on target population measures on a schedule in a format and process required by SBHIP, the Plan, or as otherwise agreed in writing between the Parties.

ii. School District will regularly report performance measures to CalOptima consistent with the specifications required in the Plan and by the SBHIP.

7. **CalOptima Responsibilities.**

A. Monitoring Project Milestones and Measures. CalOptima will evaluate all information provided by School District related to implementation of the Plan(s) to ensure School District's compliance with the Plan and track School District's goals

and milestones under the Plan.

B. Reporting to DHCS. CalOptima will report to DHCS on the Plan status as specified in the terms of the Plan(s), the terms of federal approval for the SBHIP, and any applicable DHCS-issued guidance.

C. Administration of Project Funds.

i. *Initial Payment*. Within [XX] days of CalOptima's selection and acceptance of the Plan, CalOptima will provide initial payment to School District, as set forth in the terms of the Plan and SBHIP.

ii. *Milestone Payments*. Subsequent to the initial payment, all ongoing payments to School District will be tied to achieving practice redesign components, milestones, or defined progress toward goals required by terms of SBHIP and the Plan. CalOptima will remit milestone payments to School District within [XX] days of School District's successful demonstration to CalOptima of each milestone achievement per the terms of SBHIP and the Plan. CalOptima may adjust milestone measurement and related payments consistent with the terms of a CAP. CalOptima will not make any milestone payments to School District until all of School District's past due reporting is completed to CalOptima's satisfaction.

8. **Liaison.** CalOptima and School District will each designate a liaison(s) to serve as a point of contact for activities performed related to this MOU.

9. **MOU Monitoring.** CalOptima and School District will meet on a mutually agreed upon frequency, or upon request a Party's to monitor the performance of parties' responsibilities related to this MOU.

10. **Dispute Resolution.** If there is a dispute that cannot be resolved by the Parties under Section 9, either Party may submit a request for resolution to DHCS. A Party shall give the other Party five (5) business days' notice of its intent to submit a request for resolution.

11. **Notice and Correspondence.** All notices and correspondence concerning this MOU shall be in writing and sent to:

SCHOOL DISTRICT
Attn:
Address:

CALOPTIMA
Attn:
Address:

12. **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and School District acknowledge and agree that the obligations of CalOptima under this MOU are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability under this MOU.

13. **Independent Contractor**. The Parties intend to establish an independent contractual relationship under this MOU rather than an employer/employee relationship. School District agrees that neither it nor its employees or agents are employees, agents, or legal representatives of CalOptima for any purpose, and nothing in this MOU shall be construed to create a partnership, joint venture, or employment contract between the Parties.

14. **Amendments**. Except as otherwise provide herein, the Parties may amend this MOU only in writing and signed by both Parties; provided, however, that if any law, rule, or regulation applicable to this MOU, or any interpretation thereof by any court, is modified or implemented during the term of the MOU in a way that materially changes the terms of the MOU ("**Regulatory Change**"), CalOptima may, upon written notice to School District, amend the MOU to the minimum degree necessary to comply with the Regulatory Change.

15. **Assignment**. School District may not assign or delegate any obligations or rights under this MOU without the prior written consent of CalOptima.

16. **Counterparts**. This MOU may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

17. **Waiver**. Any failure of CalOptima to insist upon strict compliance with any provision of this MOU shall not be deemed a waiver of such provision or any other provision of this MOU. To be effective, a CalOptima waiver must be in a writing that is signed and dated by CalOptima.

18. **Governing Law**. This MOU shall be governed by the laws of the State of California, and the Parties consent to venue and personal jurisdiction over them in Superior Court in Orange, California, and in U.S. District Court for the Central District of California, as applicable, for purposes of construction and enforcement of this MOU.

19. **Authorizations**. Each Party warrants that it has the full right, power, and authority to enter into and fully perform its obligations under this MOU and the execution, delivery, and performance of this MOU by that Party does not conflict with any other agreement to which it is a party or by which it is bound.

20. **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this MOU, and no implication shall be drawn against any Party by virtue of the drafting of this MOU.

21. **Recitals and Exhibits**. The recitals and exhibits set forth in this MOU are made a part of the MOU by this reference.

WHEREFORE, School District and CalOptima have executed the MOU in the County of Orange, California.

School District:

Signature: _____

Name: _____

Title: _____

Date: _____

CalOptima

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT 1
SBHIP Targeted Implementation Plan

[insert Targeted Intervention Implementation Plan Proposal document]

CalOptima Health Board Action Agenda Referral

Action To Be Taken May 4, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

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

Recommended Actions
1. Authorize CalOptima Health's Chief Executive Officer (CEO) to allocate and distribute Student Behavioral Health Incentive Program (SBHIP) incentive payment funds per the proposed incentive funding plan in an aggregate amount not to exceed $25.5 million;
2. Authorize CalOptima Health's CEO to issue a notice of funding opportunity for grants to serve school-aged children and youth in Orange County; and
3. Authorize funding for and distribution of incentive payment prior to CalOptima Health's receipt of SBHIP program incentive dollars from the State of California.

Background/Discussion
The SBHIP is a Department of Health Care Services (DHCS) 3-year state initiative incentive program from January 1, 2022, to December 31, 2024. The intent of SBHIP is to establish and build infrastructure, partnerships, and capacity for school-based behavioral health services in collaboration with managed care plans, local education agencies (LEAs) and county mental health plans. DHCS determined that CalOptima Health is eligible to receive incentive payments up to $25,459,676.

The Board has approved two actions related to SBHIP. The first action on December 20, 2021, authorized the CEO to send a letter of intent by January 31, 2022, to notify DHCS of CalOptima Health's intent to participate in the 3-year SBHIP. The second action on August 4, 2022~~2023~~, authorized the CEO, with the assistance of legal counsel, to execute memorandums of understanding and contracts with SBHIP grantee(s) upon selection and approval by the DHCS. *Rev. 5/4/2023*

During 2022, as instructed by DHCS, Orange County Department of Education (OCDE) and all 29 Orange County (OC) School Districts as the LEAs and CalOptima Health completed the required needs assessment to identify students' behavioral health needs and service gaps. CalOptima Health was required to select four targeted interventions from DHCS's approved list based on the results of the needs assessment. The LEAs chose Children's Hospital of Orange County (CHOC), Western Youth Services (WYS), and Hazel Health as partners to implement the following four targeted interventions:

1) Behavior Health Screenings and Referrals
2) Building Stronger Partnerships to Increase Access to Medi-Cal Services
3) Technical Assistance Support for Contracts
4) IT Enhancements for Behavioral Services

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On March 8, 2023, DHCS approved CalOptima Health for the four targeted interventions. The eligible funding allocation is as follows:

Allocation Description	Eligible Allocation	Status
Needs Assessment – 50% prior to completion	$217,500	Allocation received on June 14, 2022
Needs Assessment – 50% fully completed	$217,500	Expected to be received by May 2023
Targeted Interventions – 50% of the maximum allocation incentive	$12,512,338	Expected to be received by May 2023
Medi-Cal MCPs submit Bi-Quarterly (6-month) Report due 6/30/2023, 12/31/2023, 6/30/2024	Est. $9,384,253 Up to 75% of the targeted intervention remaining allocation	Expected 10/2023, 4/2024 and 10/2024
Medi-Cal MCPs submit Project Outcomes Report for each targeted intervention due December 31, 2024	Est. $3,128,085 Up to 25% of the targeted intervention remaining allocation	Expected 4/2025
	Total $25,459,676	

CalOptima Health requests Board approval for the proposed SBHIP Incentive Funding Plan for program years 2023-2024.

Entity	Description	Amount	Method
CalOptima Health	Program Support Positions (example: administrative, clinical, contracting)	Up to $200K	N/A
Children's Hospital Orange County (CHOC)	1) Build out of ten (10) new Well Spaces • Staff to provide consultation and supervision to establish the clinical model and coordination of the new Well Spaces. • Staff to provide quality monitoring services of the new Well Spaces. 2) Establish: • Emergency Department/Intensive Care School Transition Coordinator. • Staffing for the Mental Health Crisis Clinic for direct linkage from schools to CHOC for in person or telehealth mental health services. • Mental Health services for deaf and hard of hearing students. • Autism Comprehensive Care Program for students that have comorbid autism spectrum disorder and/or similar neurodevelopmental conditions and acute/severe mental health concerns (e.g., depression, suicidal ideation/behaviors, anxiety, etc.) between the ages of 12 and 17.	Up to $2.1M	Contract

Western Youth Services (WYS)	1) Develop a Behavioral Health Curriculum tailored for OC LEAs. 2) Train LEAs on core clinical competencies, including screening tools, adverse childhood experiences and prevention, and early intervention strategies to address behavioral health issues in the school setting. 3) Consultative support services post-training.	Up to $802K	Contract
Hazel Health	Implement a behavioral health telehealth platform for all 29 school districts that all 442K students (uninsured, Medi-Cal, and private) can access to receive behavioral health telehealth counseling services. This includes: 1) The technology infrastructure and equipment. 2) Dedicated implementation team for schools, which includes: • Initial and ongoing implementation and training. • Communication and marketing material and support. • Community engagement team. • Outcome reporting (utilization, time to care, number of community referrals). 3) Coordination of care for all students that use the telehealth service. Ex: linkage to county and or long-term services or supports. **Note:** Hazel Health is contracted with many private insurers and will contract with CalOptima Health. Hazel Health will bill the appropriate insurer for allowable behavioral health services separately from SBHIP funds for the behavioral health telehealth platform.	Up to $8.4M	Contract
Grants For Organizations Serving Medi-Cal School-Aged Children and Youth in Orange County	To apply for the grant, organizations may fall under the following categories: 1) Needs assistance to create or expand behavioral health services for special populations, for example: foster youth, students with developmental disabilities. 2) Needs infrastructure or capacity building assistance. 3) Needs assistance to create an innovative behavioral health program serving school-aged children and youth for services not covered under Medi-Cal.	Up to $3.5M	Notice of Funding Opportunity
All 29 Orange County LEA/School Districts	1) Hiring additional behavioral health clinical staff (e.g. social worker, school counselors, school psychologists), and administrative staff. 2) Training and material development. 3) Implementation of a secure, HIPAA-compliant electronic health record (EHR). 4) Billing systems enhancements and/or billing administrator.	Up to $10.0M	Contract
Remaining Unallocated Budget		Up to $471K	
Total		$25.5M	

Staff will return to the Board at a future meeting with recommendations on the remaining unallocated and unused SBHIP budget or in the event there are adjustments to the forecasted SBHIP funding levels from DHCS.

Monitoring and Oversight

The State requires specific SBHIP performance requirements to be reported by CalOptima Health every six months on the approved project plans. CalOptima Health's Behavioral Health Integration (BHI) department created a tool to track the performance requirements and activities identified for each of the four targeted interventions. CalOptima Health will require the SBHIP partners (LEAs, CHOC, WYS, Hazel Health) and grantees to meet all contractual and grant provisions to ensure performance of targeted interventions and comply with reporting requirements. Partners and grantees will be required to submit timely and accurate reports on a quarterly basis on the targeted intervention measures.

Fiscal Impact

The aggregate amount payable is not anticipated to exceed $25.5 million, the estimated maximum earnable amount of incentive payments DHCS has allocated to CalOptima Health. If CalOptima Health is able to earn the maximum amount, the fiscal impact of the three (3)-year SBHIP is projected to be budget neutral.

CalOptima Health reserves the right to adjust funding from partners and grantees in the event funding from DHCS is insufficient to support the proposed funding plan or to recoup funds for lack of demonstrating effort and performance against targeted intervention measures.

Rationale for Recommendation

CalOptima Health recommends proceeding with the requested actions in order for the SBHIP activities to continue. CalOptima Health BHI leadership will bring additional funding recommendations and/or updates to the Board.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. LEA TI Tracker - Example

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Approved	N/A	N/A
8/4/2022	Approved	N/A	N/A

/s/ Michael Hunn — **Authorized Signature**

04/26/2023 — **Date**

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Exhibit - LEA TI Tracker - Example

LEAs/Partners Targeted Intervention Implementation Progress:	Entity / LEA:
1) Describe, clearly and in detail, for each selected LEA, the progress made towards implementing the selected intervention during this bi-quarterly segment. Provide documentation evidencing the level of progress reported.	
2) Identify the current status of the SBHIP targeted intervention: (On Track / Not On Track)	
3) If the project is Not On Track, has SBHIP Technical Assistance been contacted? (Yes / No)	
4) If the SBHIP targeted intervention is not on track, explain, clearly and in detail, why and identify what actions will be taken to remedy the current course. If the project is on track, write N/A.	
5) Have there been any changes in SBHIP partners based on the Project Plan submission? (Yes / No)	
6) If changes have been made, describe clearly and in detail, why.	
7) Have there been any changes to the student population initially identified as recipients of the selected intervention? (Yes / No)	
8) If changes have been made, describe clearly and in detail, why.	
9) 7 - Please identify, clearly and in detail, any current internal SBHIP challenges experienced in connection with this project at this point.	
10) Please identify, clearly and in detail, any current external SBHIP challenges experienced in connection with this project at this point.	

TI Significant Project Markers/Task	Entity or LEA
BH Screening and Referrals	
Discovery Phase:	
Jan-Jun 2023	
Conduct School Infrastructure Assessment	
Research Screener Tool Options	
Jul-Dec 2023	
Identify Intervention Budget Allocation	
Planning/Design Phase:	
Jul-Dec 2023	
Identify Business/Technical Requirements	
Develop Scope of Work	
Select Appropriate Universal Validated Screener Tools	
Jan-Jun 2024	
Identify Technical Requirements	
Develop Individual LEA Implementation plans	

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
14. Approve Actions Related to the Street Medicine Program City Expansion

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
1. Approve the Notice of Interest Opportunity Evaluation Committee recommendation for one additional host-city for the expansion of CalOptima Health's Street Medicine Program.
2. Approve the scope of work for the request for qualifications to identify a provider to implement CalOptima Health's Street Medicine Program in the newly selected city.
3. Appropriate up to $4.3 million in existing reserves to fund the two-year grant agreement with the street medicine provider selected through the request for qualifications process.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of street medicine. On May 5, 2022, the Board approved the Street Medicine Program scope of work (SOW). On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare in Action to provide street medicine canvasing-based services. The pilot launched in Garden Grove on April 1, 2023. Based on the success of the program in Garden Grove, on October 5, 2023, the Board unanimously voted to:

1. Authorize CalOptima Health staff to expand CalOptima Health's Street Medicine Program into two additional cities;
2. Approve the notice of interest opportunity process that would be released to cities, including commitments from CalOptima Health as well as evaluation criteria based on a series of questions; and
3. Approve the SOW for the request for qualifications (RFQu) to identify providers capable of implementing the Street Medicine Program.

CalOptima Health launched the RFQu for street medicine providers on November 9, 2023. On December 7, 2023, the Board authorized CalOptima Health to expand its Street Medicine Program to the cities of Anaheim and Costa Mesa. On March 7, 2024, the Board approved (i) Celebrating Life Community Health Center to provide street medicine services in Costa Mesa and Healthcare in Action to provide street medicine services in Anaheim and (ii) an additional $1.8 million in existing reserves be allotted to help fund the street medicine provider grant agreements. The programs launched on August 12, 2024, and September 3, 2024, respectively.

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In accordance with CalOptima Health's strategic priority of overcoming health disparities, and based on the success of the Street Medicine Program, on December 5, 2024, the Board unanimously voted to approve a notice of interest opportunity to identify one additional host-city for the expansion of CalOptima Health's Street Medicine Program. On December 6, 2024, the notice of interest opportunity launched, and it was closed on January 17, 2025.

Discussion

To expand CalOptima Health's existing Street Medicine Program, a committee of evaluators from CalOptima Health reviewed and scored the four applications received for the Street Medicine Notice of Interest Opportunity. Scores for all four applications are as follows:

City	Score
Santa Ana	54.75
Huntington Beach	46.75
Orange	45.5
Westminster	42.75

Using the Board approved evaluation criteria below, the evaluation committee is recommending that the Street Medicine Program expansion be awarded to the highest scoring city, Santa Ana. With Board approval, CalOptima Health staff will begin collaborating with the selected city to ensure seamless integration of its Street Medicine Program with consideration of the city's broader endeavors to address homelessness.

	Criterion	Maximum Points	Basis for Assigning Points
1.	CalOptima Health core value alignment, including commitment to treat individuals with dignity and respect.	20	City's demonstrated commitment to trauma-informed, inclusive, person-centered programs and those that align with harm-reduction principles.
2.	Comprehensive, existing efforts and strategies to address homelessness.	15	City must demonstrate experience and commitment to addressing the homelessness crisis.
3.	Existing partnerships and community involvement.	15	City must describe existing partnerships that will positively contribute to the Street Medicine Program.
4.	Uploaded letter of interest.	5	Application portal includes a letter of interest that must be signed by the city manager.

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5.	All attestations complete.	5	Application portal includes attestations that must be made regarding the Street Medicine Program.
Total Earnable Points		**60**	

With the expansion to an additional city comes the need for an additional street medicine provider. Based on current program operations, CalOptima Health staff has updated the SOW to be used in the RFQu to identify an additional street medicine provider. More specifically, staff added language as it pertains to CalOptima Health's Care Traffic Control. CalOptima Health staff requests that the Board approve the updated SOW included as Attachment 1. With Board approval, the RFQu will launch on March 7, 2025. At closing on April 18, 2025, a committee of evaluators from CalOptima Health will review and score the submissions. CalOptima Health staff will request the Board's approval of the selected Medi-Cal provider and enter into a grant agreement with the selected provider at the June 2025 meeting.

Like the existing Street Medicine Programs, the program operating in the city of Santa Ana will be designed to become financially sustainable through the implementation of the California Advancing and Innovating Medi-Cal (CalAIM) services. CalOptima Health staff determined that it takes approximately two years of operations to achieve sustainability. Therefore, staff will develop a two-year grant agreement. To fund the grant agreement, staff requests an appropriation of up to $4.3 million from existing reserves to fund the remaining grant cost.

Fiscal Impact
An appropriation of up to $4.3 million from existing reserves will provide funding for the two-year grant agreement with the street medicine provider selected through the RFQu process.

Rationale for Recommendation
In order to engage CalOptima Health members experiencing homelessness where they are and on their own terms and to reduce or eliminate barriers to medical and social care, CalOptima Health staff recommends that the Board expand the Street Medicine Program to the city of Santa Ana in 2025.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Street Medicine Program Scope of Work

/s/ Michael Hunn *02/28/2025*
Authorized Signature **Date**

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CalOptima Health Street Medicine Program
Scope of Work

I. OBJECTIVE

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value of the needs of each person. CalOptima Health is well-positioned to address its unsheltered member's health and housing with its partnership-driven Street Medicine Program. Street Medicine includes health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. The fundamental approach of Street Medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. Working in collaboration with various county, city, and community organizations, Street Medicine's ultimate goal is to address and improve the overall health outcomes of the unsheltered, unhoused individuals served.

II. SCOPE OF WORK BASICS

CalOptima Health's Street Medicine Program is a critical piece of a larger, comprehensive approach to caring for our neighbors living on the street and on their journey home. CalOptima Health's overall approach relies on three integrated components: (1) outreach and engagement; (2) coordinated medical care that meets people where they are; and (3) comprehensive ECM and Community Supports. Together, these components address acute health concerns and deploy integral preventative care, moving beyond stop-gap medical services to build the types of relationships that support a person's move home.

More specifically, CalOptima Health is looking for providers who can implement CalOptima Health's Street Medicine Program in [identified city], which will be dictated in the final Grant Agreement with CalOptima Health. It is understood that those experiencing homelessness can be transient in nature and services may sometimes be provided outside of city limits. The service area will be broken up into a number of zones. Zones will be determined with the knowledge from city officials as well as other community partners who are familiar with and serve within the boundaries of the defined service area. Each Coordination Care Team will be responsible for canvassing and providing services to the members found/enrolled in their zones. This will make for a more efficient use of time and resources and will promote consistency for the members enrolled in the program. The Medical Care Team will rotate throughout the zones in a routine fashion. Flexibility will be considered based on individuals' needs. Of note, it is understood that while staffing up a new location, fewer staff will likely be used to cover most of the geographical area of the program. As the program grows, more staff will be hired, and zones will be established.

Services will be provided in the field with a canvassing based approach by both Coordination Care Teams and Medical Care Teams. The Coordination Care Team members are responsible for providing ECM and Housing Navigation (and additional housing-related Community Supports, as applicable) to individuals who agree to participate in those services, routine face to face visits to address various needs of the members and scheduling appointments with the Medical Care Team. The Medical Care Team will be responsible for primary medical care including, but not limited to, ongoing medical care, ordering and reading labs, prescribing medications, referrals to specialists as needed and urgent care, as needed. The Medical Care Team will offer all enrolled patients the opportunity to serve as their Primary Care Physician (PCP). If interested, the Coordination Care Team will work with CalOptima Health to make arrangements. Of note, the patients care shall never take place in the street medicine provider's office location.

To ensure proper care and support of patients enrolled in the program, service provision standards have been established. For the Medical Care Team, who serves a patient panel of 200, there is to be a minimum of one patient encounter every 60 days, varying on acuity of medical need(s). For

the Care Coordination Team, who each carry 25 patients, there is to be a minimum of one face to face patient encounter every 14 days. Services will likely be provided more frequently based on each patient's specific needs. The Street Medicine Team members will work at the "top of their license" to ensure efficient and safe care is delivered to each patient. Further, the Team will regularly meet with CalOptima Health staff to discuss the program as well as other partners.

Note, providers are also expected to follow CalOptima Health's ECM Policy Guide and Community Supports Policy Guide, staffing requirements, documentation requirements, meeting requirements and reporting requirements, including entering data into Care Traffic Control, as established by CalOptima Health. Entities deemed qualified will be informed on and held to the standard of all the above.

1. PRODUCTS/SERVICES

CalOptima Health's Street Medicine Program providers will ensure their staffing model meets the needs of the population served utilizing CalOptima Health Street Medicine Program standards.

Minimum staffing requirements for a street medicine team with a panel of 200 patients should include (but not be limited to):

a. A supervising Medical Doctor
b. One dedicated clinical provider such as Nurse Practitioner (NP), or Physician Assistant (PA)
c. One clinical support partner such as a nurse (RN/LVN)
d. One Program Director
e. One Program Manager
f. One Coordination Care Team Supervisor
g. Eight Peer Navigators
h. One Mental Health Professional

Suite of medical services provided by Street Medicine provider, could include, but not be limited to:

a. Primary Care Services
b. Urgent care: acute infection, cough, UTI, etc.
c. Wound care
d. Vaccinations
e. Point of care testing (Urine dipstick [macroscopic urinalysis], urine hCG [pregnancy], whole blood creatinine, whole blood electrolytes, whole blood glucose, whole blood hemoglobin, COVID-19 antigen, sexually transmitted infections such as HIV/AIDS, syphilis, etc.)
f. Medication reconciliation and review
g. Prescription delivery (or able to prescribe for delivery)
h. Injectable anti-psychotics and other street psychiatry services
i. Age-appropriate health screenings
j. Chronic disease management
k. Referral to hospital on voluntary or 5150 basis
l. Primary care provider and specialist referral, as well as appointment scheduling, where applicable

m. Appropriate harm reduction methods, as needed, and in coordination with the Orange County Health Care Agency (e.g., Naloxone distribution and medically assisted treatment, etc.)

2. PROVIDER'S RESPONSIBILITIES

CalOptima Health's Street Medicine Program providers are responsible for meeting the following criteria to ensure services are provided in the most effective manner possible:

a. Able to provide services to all unsheltered CalOptima Health members encountered within the identified geographic location
b. Maintain consistent recurring schedules during traditional hours and staff as established by CalOptima Health.
    1) Be prepared to spend no less than 4 hours in the field on a given day.
c. Ability to serve as medical home/ primary care provider, as appropriate.
d. Provide CalAIM ECM and Community Support services to individuals enrolled in the program.
e. Have the necessary medical equipment to provide services on the street or in the mobile unit provided by CalOptima Health, including, but not limited to:
    1) Stethoscope
    2) Blood pressure cuff
    3) Pulse oximeter
    4) Wound care supplies
    5) Point of care testing supplies
    6) Frequently used medications for immediate dispensation: vaccines, insulin, diabetes medication, etc.
    7) Other medical supplies, as appropriate
f. Arrange transportation for appointments at brick and mortar healthcare offices.
g. Make telehealth equipment available and provide services through this modality in a manner consistent with CalOptima Health's Policies and Procedures, meeting all regulatory requirements.
h. Follow CalOptima Health identified clinical treatment protocols for specific conditions that can be treated in the street, to include post discharge planning and care transitions.
i. Able to refer to emergency room or recuperative care, as needed.
j. Provide connection to housing by way of Homeless Management Information System (HMIS) and Coordinated Entry System (CES) as well as other methods to secure permanent housing
k. Develop materials (e.g., schedules, flyers, etc.), in collaboration with CalOptima Health, that can be shared publicly and with other service providers.
l. Submit claims using program specific billing guidelines and/or encounter tracking reports as developed by CalOptima Health and indicated in final contract agreement. Routinely reconcile claims reports.
m. Submit, track and report outcome data as determined by CalOptima Health.
n. Participate in Care Traffic Control by routinely providing data to CalOptima Health

3. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health will evaluate the capacity of each applicant to determine current state of infrastructure and information sharing capabilities, and will also be responsible for the following:

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a. Serve as the lead of its Street Medicine Program. This includes being the primary point of contact with the city as well as all partners.
b. Educate the selected applicants on CalOptima Health's Street Medicine Program requirements.
c. Develop and maintain all program contracts, future policies and procedures, and any other documents required by DHCS or other regulatory entities.
d. Development of an incentive structure that enables providers to meet the requirements of the program.
e. Providing timely compensation and/or payment of associated incentives.
f. Support with development of materials, as noted above under Section 2h.
g. Train providers on documentation requirements and program-specific Billing Guidelines, as applicable.
    1) Includes provision of tools for data collection.
h. Member interpretation services will be provided by CalOptima Health, as is customary/standard practice for members.
i. Training for CalAIM Community Supports and Enhanced Care Management (ECM) to support continuity of care, including:
    1) Training and access to software or other programs such as SafetyNet Connect
j. Convene Street Medicine teams on a regular basis (frequency to be determined) to assess program needs and opportunities for improvement.
k. Provide funding for the CalOptima-designed Street Medicine Program van
l. Convene Steering Committee meetings with all necessary stakeholders, as needed.
m. Provide office space for Street Medicine Team as well as van parking
n. Serve as the branding lead for the Program, including providing co-branded Street Medicine items (van wrap, shirts, flyers, etc.) that the selected provider will agree to use and wear
o. Maintain an updated CalOptima Health Street Medicine Operations Manual

4. DELIVERABLES

Prior to the program start date indicated in final contract, participating providers are expected to have the necessary infrastructure in place (e.g., functional mobile units, medical supplies, technology, staff, etc.).

Street Medicine providers will be expected to meet the following deliverables throughout the course of the program:

a. Submit accurate and timely claims for CalOptima Health members following CalOptima Health's Billing Guidelines, within one month of service delivery.
b. Submit documentation, as defined in the final contract within the specified timeframe, in alignment with final incentive payment structure.
c. Submit accurate and timely data about the individuals being served by the program.
    1) This includes providing data to Care Traffic Control
d. Tracking unique and total contacts per day with notation of broad encounter outcomes using CalOptima Health programs and/or other tracking mechanisms.
    1) Type of clinical service to be document (e.g., primary care services, specialty care, etc.), and
    2) Documentation of other services (e.g., application assistance for non-clinical contacts) if provided by a partner in the field during the encounter.

5. PERFORMANCE GUARANTIES/MEASURES

Providers will be expected to submit all data on a weekly basis, in alignment with the final incentive payment structure and as defined in the grant agreement and contract.

III. ADDITIONAL AREAS TO CONSIDER

A. CULTURAL AND LINGUISTICS

Street Medicine providers will ensure that services are provided in a manner consistent with CalOptima Health policies and procedures. It is expected that the provider is able to provide documentation attesting staff or partners have received trauma-informed and recovery-centered training.

B. MEMBERSHIP/ELIGIBILITY MANAGEMENT

Individuals enrolled must have CalOptima Health Medi-Cal and be experiencing unsheltered homelessness. This includes individuals who lack an adequate nighttime residence and/or who have a primary residence that is a public or private place not designed for ordinary use or habitation.

IV. ADDITIONAL REQUIREMENTS

Provider must be able to implement CalOptima Health's Street Medicine Program Framework as described in Scope of Work (above).

1) Provider must be able to provide services to all individuals enrolled and serve as medical home/primary care provider, as appropriate. Provide explanation on how you meet this.
2) Provider must be a credentialed Medi-Cal Provider and able to submit claims to CalOptima. Please confirm and provide Medi-Cal Provider number.
3) Provider must have completed documented trauma-informed care training, recovery-focused and person-centered training. Please describe how Company has completed these trainings and will continue to provide regular training in the areas described above.
4) Provider must meet the staffing requirements as specified above in the SOW. Please confirm the understanding.
5) Provider must be willing to provide services out of a mobile unit designed and funded by CalOptima Health. Provide explanation on how this will be met.
6) Provider must be able to maintain consistent staff coverage on recurring schedules. Confirm and provide explanation on how this requirement will be met.
7) Provider must be able to provide connection to housing by way of providing CalAIM Enhanced Care Management and Community Supports, as well as enrollment in the CES and HMIS. Please identify if your organization is contracted as a CalAIM ECM and/or Housing Services provider. Please also identify if your agency currently is trained in and utilizes CES and HMIS.
8) CalOptima Health has launched a platform called Care Traffic Control (CTC) to help measure program outputs and outcomes as well as track and monitor that Providers are incompliance with the Operations Manual. CTC requires that Street Medicine Providers provide weekly data files to CalOptima Health from its Electronic Health Record. Please confirm your agency has an IT department that will be able to ensure this requirement is met within the first two months of contract signature.
9) Provider must follow CalOptima Health's Street Medicine Operations Manual if selected. This includes acknowledging CalOptima Health as the lead of its Street Medicine Program. Confirm understanding of this requirement.

10. Describe any and all partnerships your organization currently has with the partners below:
    1. Homeless shelters/navigation centers
    2. Other Street medicine programs or mobile clinics
    3. Other organizations who serve the unsheltered
    4. Recuperative care sites
    5. Post-hospitalization housing
    6. Hospitals
    7. Emergency Personnel
    8. County of Orange Health Care Agency, including Outreach & Engagement

V. Geographical Zone

Confirm understanding that [enter city] is the selected city for this Street Medicine expansion.

CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Approve Actions Related to the Equity and Practice Transformation Payment Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director of Network Operations, (714) 347-3292

Recommended Action

1. Authorize allocation of $1.44 million in Medi-Cal Managed Care Plan Equity and Practice Transformation Program Planning Incentives to fund:
    a. Up to $800,000 for a contract to provide coaching and support to Equity and Practice Transformation Program practice sites; and
    b. Up to $640,000 in program support costs.
2. Authorize the Chief Executive Officer to release a request for proposals, select a vendor, and negotiate and execute a contract for coaching and support services to practice sites through a formal procurement in accordance with CalOptima Health's Board-approved Purchasing Policy.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background and Discussion

The Equity and Practice Transformation (EPT) Program is a three-year, $140 million directed payment program funded jointly by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services. The EPT Program aims to improve access for Medi-Cal enrollees to advance equity, reduce disparities, and invest in building the foundation of patient-centered population health models that align with future value-based payments. The program began in January 2024 with a cohort of 205 primary care practices across 52 counties selected to participate. There are three components to the EPT Program:

1. $25 million for Medi-Cal Managed Care Plan (MCP) initial provider planning incentive payments to encourage MCPs to support EPT practices in assessing the ability to transform their practices and meet program goals;
2. $97 million for EPT provider directed payments: $250,000 base payments for each participating practice plus a $20 per assigned member payment for achieving milestones; and
3. $18 million for a statewide learning collaborative to ensure successful implementation of the program.

Seventeen primary care practices in Orange County currently participate in the program; of those, 14 practices have designated CalOptima Health as their Medi-Cal MCP. Together, these practice sites are eligible for up to $5,362,020 in EPT provider directed payments. Practices must submit up to 8 comprehensive reports to DHCS for deliverables that include milestones, key performance indicators, and data reports. The reports are submitted on a semiannual basis. If the practices meet the metrics and are approved by DHCS, they will receive their payment. Without considerable individualized coaching and training, the practices will be at a disadvantage in developing policies, workflows, and protocols for

the practice to support the deliverables. Metrics for the upcoming May deliverables include the completion of annual assessments, HEDIS-like reporting for their population of focus, and key performance indicator reports, including a data implementation plan.

CalOptima Health received $2.266 million in incentive payments from DHCS to support the success of its participating practices. To date, CalOptima Health has used $50,000 of the incentive payments to support training for the 14 practice sites to help them meet their first milestone.

Staff requests the Board allocate up to $1.44 million of the $2.216 million in unallocated funds as follows:

- Up to $800,000 to contract with a qualified vendor to provide continued coaching and support for the 14 practice sites, including providing a site-specific assessment of performance gaps; site-specific training and coaching to achieve quality performance metrics and other key performance indicators; implementation of data exchanges at each site with two new trading partners; and support the site with completing all required submissions to earn the directed payments.
- Up to $640,000 to fund short-term CalOptima Health staff for a 3-year period. This will ensure CalOptima Health's compliance with program close-out activities and supplemental reporting after the program's conclusion. Staff will include a project manager to drive the project across CalOptima Health's internal departments, the 14 practice sites, the statewide learning collaborative partner, and DHCS; and staff in Quality Improvement to align the EPT Program goals and quality performance targets with existing CalOptima Health quality initiatives to eliminate duplication and export best practices to additional practices.

Staff will return to the Board at a future meeting with requests to allocate the remaining $776,000 in unallocated funds toward additional investments to support new or revised DHCS EPT requirements.

Fiscal Impact
The recommended action is fully funded from the Medi-Cal MCP EPT Program Planning Incentives that CalOptima Health has received from DHCS and has no additional net fiscal impact to CalOptima Health.

Rationale for Recommendation
The recommended action allows CalOptima Health to meet the intent of the MCP provider planning incentive payments to support the 14 Orange County practices participating in the EPT Program to meet program goals.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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Attachment to the March 6, 2025, Board of Directors Meeting – Agenda Item 15

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Celebrating Life Community Health Center	27800 Medical Center Road, Suite 109/110	Mission Viejo	CA	92691
Families Together of Orange County	9918 Katella Ave., Suites A-C	Anaheim	CA	92804
Korean Community Services, Inc.dba: KCS	7212 Orangethorpe Ave., Suite 9-A	Buena Park	CA	90621
North Orange County Reg Health Foundation dba Family Health Matters	1182 N Euclid Street	Anaheim	CA	92801
Saint Youstina	809 S Main St., Suite A	Santa Ana	CA	92701
Serve the People Community Health Center	1206 E 17th St., Suite 101	Santa Ana	CA	92701
S A Medical Center Inc. dba: San Antonio Medical Center	610 W 17th	Santa Ana	CA	92706
Latino Health Services Medical Group dba Clinica Medica Familiar De Santa Ana	517 N Main Street	Santa Ana	CA	92701
Mohan Kumaratne, MD, Inc	17692 Beach Blvd., Suite 200	Huntington Beach	CA	92647
Cedars Family Medicine Inc.	18021 Sky Park Circle, Suite G	Irvine	CA	92614
Children's Hospital of Orange County (CHOC Children's)	1201 W La Veta Ave. Attn: Primary Care Administration	Orange	CA	92868
Sangeeta Patel dba Docs For Kids	13372 Newport Ave., Suite B	Tustin	CA	92780
CHOICE Health Network	408 S Beach Blvd., Suite 111	Anaheim	CA	92804

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Actions Related to Professional, Ancillary, Hospital, and Health Network Contract Amendment and Templates for Covered California

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Approve new contract amendment and templates for Covered California, effective January 1, 2027, and forward.
2. Authorize the Chief Executive Officer, or designee, to utilize the contract templates to negotiate agreements with new providers or amend contracts with existing contracted providers to participate in CalOptima Health's Covered California plan.
3. Authorize the Chief Executive Officer, or designee, with the assistance of legal counsel, to make future changes to Covered California provider contract templates to comply with statutes, regulations, or sub-regulatory guidance and CalOptima Health policies and procedures.

Background and Discussion

On October 3, 2024, the CalOptima Health Board of Directors (Board) directed the Chief Executive Officer (CEO) to request the Orange County Board of Supervisors (BOS) amend CalOptima Health's enacting ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS approved an amended ordinance to allow CalOptima Health to pursue a contract with Covered California.

In order to participate in Covered California, CalOptima Health must offer a comprehensive provider network to ensure member access to and continuity of care of covered services, as required by both Covered California and the Department of Managed Health Care (DMHC).

CalOptima Health staff, with the support of legal counsel, created new contract templates and a template amendment to contract with new providers and providers currently participating in CalOptima Health's OneCare and Medi-Cal Programs that stipulate the regulatory and operational requirements and other contracted terms for participation in CalOptima Health's Covered California plan.

The provider contract templates are outlined below. Each contract and amendment will include attachments for Covered Services, Compensation, Covered California Program Requirements, and Knox-Keene Act Requirements.

Template Type	New Contract or Amendment to Existing Contract	Provider Type(s)
Provider Services Contract (PSC)	New Contract	Primary care, specialist, behavioral health, ancillary, and non-hospital facilities

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Template Type	New Contract or Amendment to Existing Contract	Provider Type(s)
Hospital Services Contract	New Contract	Hospitals and psychiatric hospitals
Amendment with Covered California Regulatory Addendum, Knox-Keene Act Requirements Addendum, and Attachment A (Covered Services) and Attachment B (Compensation) updates for Covered California	Amendment to Existing Contract	Primary care, specialist, behavioral health, ancillary, non-hospital facilities, and hospitals
Health Network Shared Risk Group Contract	New Contract	Health networks
Attachment A (Covered Services) and Attachment B (Compensation) Exhibits	Attachments to new PSC Contract	Primary care, specialist, behavioral health, ancillary, and non-hospital facilities

At the December 5, 2024, meeting, the Board approved a direct contract with Milliman, Inc. for actuarial support for Covered California financial projections and rate development. Staff will return to the Board at a future meeting to recommend execution of the Covered California provider contracts, including the rate provisions.

Staff requests the Board approve the above recommended actions, which will allow staff to begin engaging providers' interest to contract with CalOptima Health and to establish a robust provider network for Covered California. Upon Board approval, the contract templates will be submitted to the DMHC for regulatory approval.

Fiscal Impact
The recommended action has no additional fiscal impact to the Fiscal Year 2024-25 Operating Budget. To the extent there is any fiscal impact due to increase in resources related to Covered California, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation
The above recommended actions will support contracting efforts to build CalOptima Health's provider network to support CalOptima Health's goal of offering a Covered California plan.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Provider Services Contract template
2. Hospital FFS Template
3. Amendment to Existing Contract Template
4. Health Network SRG Template

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5. Medical Provider Exhibits to PSC Template (Attachment A and B)
6. Non-Medical Provider Exhibits to PSC Template (Attachment A and B)
7. PCP Exhibits to PSC Template (Attachment A and B)

Board Actions

Board Meeting Dates	Action
December 5, 2024	Contingent upon and effective immediately following a second reading and majority vote of the Orange County Board of Supervisors to adopt an amendment to Section 4-11-2 of the Codified Ordinances of the County of Orange to remove the prohibition on CalOptima Health's participation in Covered California, enact the following: 1. Approve the scopes of work related to the following Covered California consulting support contracts: a. Strategic Advice and Qualified Health Plan Application Support; b. Actuarial Support for Financial Projections and Rate Development; and c. Operational Implementation Support and Project Management; 2. Approve the release of a request for proposals related to the Operational Implementation Support and Project Management contract; 3. Make exceptions to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer, or designees, to execute the following contracts and/or contract amendments with the designated vendors without competitive procurement: a. Strategic Advice and Qualified Health Plan Application Support with Health Management Associates, Inc. through a contract amendment; and b. Actuarial Support for Financial Projections and Rate Development with Milliman, Inc. through a new direct contract; 4. Approve the creation of a restricted Covered California Start-up Reserve Fund in the amount of $4.75 million from existing reserves to fund Covered California start-up costs through December 31, 2026.
October 3, 2024	1. Adopt CalOptima Health's Covered California Guiding Principles to inform the design and development of CalOptima Health's potential participation in Covered California; 2. Authorize the continued regular convening of CalOptima Health's Covered California Stakeholder Steering Committee to inform ongoing operational and regulatory considerations for CalOptima Health's potential participation in Covered California; and 3. Direct the Chief Executive Officer, or designee, to request the Orange County Board of Supervisors to amend Section 4-11-2 of the Codified Ordinances of the County of Orange to remove the prohibition on the participation of the Orange County Health Authority in the California Health Benefit Exchange.

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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PROVIDER SEVICES CONTRACT

between

ORANGE COUNTY HEALTH AUTHORITY DBA CAL OPTIMA HEALTH

and

_____

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PROVIDER SERVICES CONTRACT

This Provider Services Contract (the "**Contract**") is effective [insert effective date] ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**") and **@@Provider Name@@** ("**Provider**"). CalOptima and Provider may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System formed pursuant to Welfare and Institutions Code § 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008.

B. CalOptima contracts with the State of California, acting through the Department of Health Care Services ("**DHCS**"), the U.S. Department of Health and Human Services ("**HHS**"), acting through the Centers for Medicare & Medicaid Services ("**CMS**"), and California Department of Aging ("**CDA**"), and Covered California to arrange and pay for health care services rendered to beneficiaries who are enrolled in CalOptima's OneCare (a dual eligible special needs Medicare Advantage plan), Medi-Cal, MSSP, Covered California, and PACE programs ("**Programs**").

C. Provider provides the items and services described in this Contract and has all certifications, licenses, and permits necessary to furnish such items and services.

D. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

Capitalized words or phrases not otherwise defined in this Contract shall have the meanings set forth below:

1.1. "**Accreditation Organization**" means any organization engaged in accrediting, certifying and/or approving CalOptima, Provider, and/or their respective programs, centers, or services, including the National Committee for Quality Assurance ("**NCQA**") and the Joint Commission.

1.2. "**Advance Directive**" means a written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make their health care wishes known.

1.3. "**Agent**" means a person who has the authority to obligate or act on behalf of Provider, CalOptima, or a Regulator.

1.4. "**Authorization**" or "**Authorized**" means the written or telephonic approval of CalOptima or its delegate for the provision or referral of Covered Services, other than Emergency Services, in accordance with CalOptima Policies, Laws, and this Contract.

1.5. "**Business Day**" means Monday through Friday, except for legal holidays under State law, which are identified on the California Department of Human Resources' State Holidays website.

1.6. "**California Children's Services ('CCS')**" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.7. "**CalOptima Policies**" means the policies and procedures relevant to this Contract, including those set forth in CalOptima's Provider Manual, provider newsletters, or other written communications to providers, and as amended from time to time at the sole discretion of CalOptima. CalOptima Policies include network management, quality management and improvement, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities, and grievances and appeals, and Provider's failure to comply with CalOptima Policies constitutes a breach of this Contract.

1.8. "**CCR**" means the California Code of Regulations.

1.9. "**CCS Eligible Condition(s)**" means a physically handicapping condition, as defined in 22 CCR §§ 41515.2-41518.9.

1.10. "**CCS-Paneled Providers(s)**" means any of the following providers when used to treat Members for CCS Eligible Conditions:

1.10.1. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with § 123800 of Chapter 3 of Part 2 of Division 106).

1.10.2. A licensed acute care hospital approved by the CCS Program.

1.10.3. A special care center approved by the CCS Program.

1.11. "**CCS Program**" means the State public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.12. "**CFR**" means the Code of Federal Regulations.

1.13. "**Claim**" means a request for payment submitted by Provider to CalOptima for services provided to a Member.

1.14. "**Clean Claim**" means a "Complete Claim" under Laws, including (as applicable) 28 CCR § 1300.71(a)(2), that also complies with the terms of this Contract and CalOptima Policies.

1.15. "**COB**" refers to the coordination of benefits determinations of the order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

1.16. "**COD**" means a direct program CalOptima administers for Members not enrolled in a Health Network. COD consists of two components:

1.16.1. COD Members who are assigned to a Community Network in accordance with CalOptima Policies.

1.16.2. "**COD-Administrative**" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal SOC, or are eligible for both Medicare and Medi-Cal.

1.17. "**Community Network**" means CalOptima's direct health network that serves Members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to primary care providers ("**PCPs**") as their medical home, and their care is coordinated through the PCP.

1.18. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of CalOptima's Board of Directors, employees, contractors, and providers comply with Laws and ethical standards. The Compliance Program includes CalOptima's fraud, waste, and abuse ("**FWA**") plan.

1.19. "**Contracted Provider**" means a provider that is contracted with Provider to provide Covered Services to Members. All Contracted Providers are considered Subcontractors.

1.20. "**County**" means the County of Orange, State of California.

1.21. "**Covered Services**" means those Medically Necessary health care items, drugs, and services that a Member is entitled to receive under the Member's Program and are identified in Attachment A. Covered Services must generally be Authorized in accordance with CalOptima's Policies, including its utilization management program, except for Emergency Services.

1.22. "**DHCS Contract**" means the contract between CalOptima and DHCS under which CalOptima arranges for the provision of Covered Services to Medi-Cal beneficiaries in the County.

1.23. "**Emergency Services**" has the same meaning, unless otherwise provided in an attachment to this Contract with regard to a specific Program, as defined in 42 CFR §§ 422.113(b) and 438.114(a).

1.24. "**Encounter Data**" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. Encounter Data records shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by Regulators.

1.25. "**Government Contract(s)**" means the contract(s) between CalOptima and the federal and/or State government, including the DHCS Contract, pursuant to which CalOptima administers and pays for Covered Services under a Program.

1.26. "**Health Network**" means a physician group under a shared risk contract, physician-hospital consortium, or health care service plan licensed under the Knox-Keene Act that contracts with CalOptima on a capitated basis to provide Covered Services to non-COD Members.

1.27. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including Regulators' operational guidance and other instructions related to the coverage, payment, and/or administration of Programs. Any state or federal statute, regulation, rule, or executive or agency order that only applies to a certain Program(s) shall only be considered part of Laws with respect to the Program(s) to which the state or federal statute,

regulation, rule, or executive or agency order applies. Laws do not include any State statute, regulation, rule, or executive or agency order preempted by federal law.

1.28. "**Licenses**" means all licenses, certifications, accreditations, approvals, and permits that Provider must have in order to participate in the Programs and furnish the items and/or services under this Contract.

1.29. "**Medi-Cal**" is the Medicaid program for the State (*i.e.,* the program authorized by Title XIX of the federal Social Security Act ("**SSA**") and the regulations promulgated thereunder).

1.30. "**Medically Necessary**" or "**Medical Necessity**" means reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity, per Welfare & Institutions ("**W&I**") Code § 14059.5(a) and 22 CCR § 51303(a). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of twenty-one (21), Medical Necessity includes the standards in 42 USC § 1396d(r) as required by W&I Code §§ 14059.5(b) and 14132(v).

1.31. "**Medical Record**" means any record kept or required to be kept by any provider that documents all of the medical services received by the Member, including inpatient, outpatient, emergency care, and referral requests and Authorizations, as required by Laws and CalOptima Policies.

1.32. "**Medicare**" means the federal health insurance program defined in Title XVIII of the SSA and the regulations promulgated thereunder.

1.33. "**Member**" means any person who is eligible to receive Covered Services and is enrolled in a Program.

1.34. "**Minimum Standards**" means the minimum participation criteria established by CalOptima that providers that must satisfy to receive reimbursement from CalOptima for items and/or services furnished to Members, as further described in CalOptima Policies.

1.35. "**MOU**" means (i) an agreement between CalOptima and another government agency that delineates responsibilities for coordinating care to Members; and (ii) a contract between CalOptima and the County that incorporates such agreements, including the Coordination and Provision of Public Health Care Services Contract.

1.36. "**Overpayment**" means a payment Provider receives that, after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Contracts, and/or this Contract.

1.37. "**Participating Provider**" means an institutional, professional, or other provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.38. "**Participation Status**" means whether a person or entity is or has been suspended, precluded, or excluded from participation in any federal and/or state health care programs and/or has a felony conviction, as specified in the Compliance Program and CalOptima Policies.

1.39. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.40. "**Privacy Requirements**" means the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), California W&I Code § 14100.2, as amended, and the implementing regulations of those laws, including CCR § 51009 and 42 CFR § 431.300 *et seq.*

1.41. "**Program(s)**" means any of the following programs administered by CalOptima: the Medi-Cal, OneCare, the Multipurpose Senior Services Program ("**MSSP**"), the Program of All-Inclusive Care for the Elderly ("**PACE**"), or Covered California. Provider participates in the specific Program(s) identified in Attachment A.

1.42. "**Regulators**" mean those government agencies that regulate and oversee CalOptima, including the HHS Inspector General, CMS, DHCS, the Department of Justice ("**DOJ**"), the DOJ Bureau of Medi-Cal Fraud, the California Department of Managed Health Care ("**DMHC**"), the Comptroller General, Covered California, and any other government agencies that have authority to set standards and oversee the performance of the Parties.

1.43. "**SOC**" means the share of cost the Member owes as part of receiving Covered Services, including co-payments, and deductibles.

1.44. "**State**" means the State of California.

1.45. "**Subcontract**" means a contract between Provider (or another Subcontractor) and a Subcontractor that agrees to provide services related to fulfilling Provider's obligations under this Contract.

1.46. "**Subcontractor**" means a person or entity that entered into a Subcontract with Provider (or another Subcontractor) related to fulfilling any of Provider's obligations under this Contract, including Contracted Providers.

1.47. "**TRI**" means the set of provider targeted rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) and implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

1.48. "**WCM Program**" means CalOptima's Whole Child Model program whereby CCS is a Medi-Cal managed care plan benefit with the goal to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
PROVIDER OBLIGATIONS

2.1. **Covered Services**.

2.1.1 Provider shall furnish the Covered Services in all areas of the County that are Authorized by CalOptima (except for Emergency Services, which do not require Authorization) and listed in Attachment A to eligible Members. Provider shall furnish such items and services

(i) in a manner satisfactory to CalOptima and its Regulators in accordance with Laws, Program requirements, Government Contracts, and CalOptima Policies, and (ii) in the same manner and in accordance with the same standards that Provider furnishes services to all other Provider patients, including the same availability and access.

2.1.2 Provider shall make Covered Services available and accessible to Members promptly and in a manner which ensures continuity of care and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

2.1.3 Throughout the Term, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, Laws, Government Contracts, Program requirements, and CalOptima Policies.

2.1.4 Neither Provider nor its Subcontractors will perform any work related to the Contract outside the United States of America without the prior written consent of CalOptima, which it may withhold in its sole discretion.

2.2. **Licensure and Qualifications**.

2.2.1 Provider represents and warrants that it has, and shall maintain during the Term, all valid and active Licenses necessary to render Covered Services, including (i) certification under and enrollment in Medicaid and Medicare; (ii) all provider and/or supplier numbers necessary to perform its obligations under this Contract, including National Provider Identifiers ("**NPIs**"); and (iii) being in good standing with State licensing boards applicable to its business, DHCS, CMS, and the HHS Officer of Inspector General ("**OIG**"), as applicable.

2.2.2 Provider shall ensure that every provider providing Covered Services and employed or engaged by Provider or Subcontractors shall at all times during the Term retain all valid licenses, certifications, and qualifications, without restriction, and meet Minimum Standards as necessary to provide or arrange for the provision of Covered Services to Members and bill for those Covered Services.

2.2.3 Provider or its delegate shall additionally verify the qualifications of all employees and Subcontractors providing services under this Contract consistent with the services to be provided. For employees and Subcontractors who have face-to-face contact with Members, Provider or its delegate shall also conduct background investigations, including county, state, and federal criminal history and abuse registry screening. Provider and its delegates shall comply with all Laws in conducting background investigations and shall exclude unqualified employees and Subcontractors from providing services under this Contract.

2.2.4 Provider's facilities, equipment, technology (hardware and software), and administrative services shall be at a level and quality necessary to meet industry standards and perform Provider's duties under this Contract and shall comply with Laws.

2.2.5 Provider shall notify CalOptima in writing and provide all correspondence with and notices from any government agency or Accreditation Organization regarding (i) investigations into Provider or its Subcontractors; (ii) citations and/or disapprovals of Provider for a failure to meet any material Law or Accreditation Organization standard; or (iii) the issuance of criminal, civil, and/or administrative sanctions (threatened or imposed) related to Provider's or a Subcontractor's licensure (including a malpractice lawsuit); FWA; (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status (including any

indictment, arrest, or conviction for a felony or for any criminal charge related to Provider's services).

2.3. **Credentialing and Recredentialing**. Prior to providing any Covered Services and throughout the Term, Provider and all Subcontractors shall be credentialed and periodically recredentialed by CalOptima and fully cooperate with CalOptima credentialing and recredentialing procedures as required by CalOptima Policies, Government Contracts, and Laws. Only providers who CalOptima has determined meet applicable CalOptima credentialing criteria may be considered Contracted Providers.

2.3.1 Provider warrants and represents that as of the Effective Date and continuing through the end of Term its employees and Contracted Providers who will render Covered Services shall meet the credentialing standards set forth in this Section 2.3.

2.3.2 Provider's physician employees and Contracted Providers who will render Covered Services shall maintain clinical privileges in good standing and without restriction at a CalOptima Participating Provider hospital.

2.3.4 During the Term, Provider's employees and Contracted Providers who will render Covered Services shall maintain their professional competence and skills commensurate with the standards of the community and attend and participate in approved continuing education courses, as required by Laws.

2.3.5 CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate for Provider's employees and Contracted Providers. Rendering Covered Services is subject to CalOptima's approval of a provider's credentialing application. CalOptima may terminate this Contract upon written notice to Provider at any time if a significant portion of Provider's employees and Contracted Providers who render Covered Services fail to meet CalOptima's credentialing, recredentialing, and/or professional competence standards.

2.4. **Professional Standards**. Provider shall exercise independent professional judgment in providing Covered Services. All Covered Services under this Contract shall be provided or arranged by duly licensed, certified, or otherwise authorized professional personnel in a manner that (i) meets the cultural and linguistic requirements of this Contract, Government Contracts, and CalOptima Policies; (ii) within professionally recognized standards of practice at the time of treatment; and (iii) in accordance with Laws and CalOptima's utilization management ("**UM**") and quality management ("**QM**") programs.

2.5. **Eligibility**. Provider shall verify a Member's eligibility for the applicable Program benefits upon receiving request for Covered Services and at the beginning of each calendar month thereafter during the continued provision of such Covered Services. For Members SOC obligations, Provider shall collect SOC in accordance with CalOptima Policies and Laws.

2.6. **Compliance with Laws and Policies**. Provider shall comply with all Laws in effect during the Term that in any manner affect Provider's performance under this Contract. This Contract shall be governed by and construed in accordance with Laws and Government Contracts. Provider shall also comply with all applicable CalOptima Policies.

2.7. **Transfer of Care**. Upon request by a Member, Provider shall assist in the orderly transfer of the Member's care to another provider. In doing so, Provider shall make available to the new provider copies of the Medical Records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of the Member. In no circumstance shall CalOptima or a Member be billed for this service. Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of CalOptima.

2.8. **UM Program**. Provider shall comply with CalOptima's UM program requirements, including:

2.8.1 Provider shall comply with all concurrent and retrospective review, referral, and Authorization requirements set forth in CalOptima Policies. If Provider fails to obtain Authorization prior to providing Covered Services to or referrals for a Member, as required by this Contract and CalOptima's UM program, or if Provider provides services outside of the scope of the Authorization obtained, then CalOptima shall have no obligation to compensate Provider for such services; Provider will be deemed to have waived payment for such services and shall not seek payment from CalOptima, its delegate(s), or the Member. Authorization is not required for Emergency Services

2.8.2 Provider shall allow CalOptima staff to initiate discussions with Provider to evaluate the appropriateness of items and services, and Provider shall comply with the evaluations and processes necessary for CalOptima to determine the Medical Necessity of items and services.

2.8.3 Provider shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct concurrent reviews of the Medical Records of Members, including on site. CalOptima staff shall notify Provider prior to conducting any on-site reviews, shall wear appropriate identification, and shall schedule times reasonable for Provider.

2.9. **QM Program**. Provider shall comply with CalOptima's QM Program and shall participate and cooperate in QM Program activities as required by CalOptima. Such activities may include (i) providing requested data; (ii) participating in assessment and performance audits and projects (including those required by Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members; and (iii) participating in QM Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for Members. Provider shall cooperate with CalOptima and Regulators regarding any complaint, appeal or other review of Covered Services, including Medical Necessity, and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or Regulators, as applicable and as required under the applicable Program.

2.10. **QM Program Performance Data**. Provider shall also allow CalOptima to use CalOptima and Provider performance data for quality and reporting purposes, including quality improvement activities, public reporting to consumers, and performance data reporting to Regulators, as required by Laws, Government Contracts, Programs, and CalOptima Policies.

2.11. **Changes in Capacity**. Provider shall provide at least ninety (90) days' prior written notice to CalOptima of any significant changes in the capacity of Provider to furnish Covered Services to Members. Provider shall use reasonable efforts to eliminate or remedy any condition that results in a significant adverse change in capacity, including closure of any facility used by Provider.

2.12. **Marketing Requirements**. Provider shall comply with CalOptima's marketing guidelines relevant to the applicable Program(s) and marketing Laws.

2.13. **Provider Information**.

2.13.1 Provider shall provide demographic and other information about its Participating Providers, employed individual providers, and facilities, as applicable and requested by CalOptima, including (i) specialties (ii) certifications; (iii) panel availability, (iv) addition of new providers; (v) mailing addresses; (vi) billing addresses; (vii) phone numbers; (viii) fax numbers; and (ix) office hours and shall promptly notify CalOptima of changes to such information during the Term.

2.13.2 CalOptima may list the name, address, and telephone number of Provider and a description of Provider's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular provider in the roster. Provider and CalOptima agree that the use of the other Party's trademarks or logos in any form is prohibited without prior written approval of that Party.

2.13.3 Provider shall notify CalOptima within five (5) Business Days when (i) Provider is not accepting new Members, or (ii) if Provider previously not accepted new Members, Provider is currently accepting new Members.

2.14. **Health Networks**. Provider acknowledges and agrees that CalOptima has delegated financial responsibility to Health Networks for certain Covered Services rendered to Members enrolled in Health Networks. Provider agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks and to contract with a Health Network under the same terms as this Contract, at the request of a Health Network. Regardless of whether Provider is contracted with a Health Network, Provider also agrees to look solely to the applicable Health Network for payment for Covered Services rendered by Provider that are the financial responsibility of the Health Network pursuant to the Health Network's contract with CalOptima, and CalOptima and Member shall not be liable to Provider for those services.

2.15. **Linguistic and Cultural Sensitivity Services**. Provider shall comply with CalOptima Policies and Laws related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, including Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services: (i) honor Members' beliefs, traditions, and customs; (ii) recognize individual differences within a culture; (iii) create an open, supportive, and responsive organization in which differences are valued, respected, and managed; and (iv) through cultural diversity training, foster in Provider staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold and concentration languages identified by CalOptima, as required by Laws, at no higher than the sixth (6^{th}) grade reading level.

2.16. **Provision of Interpreters**. Provider shall ensure that Members are provided with translation and interpreter services for Members as necessary to ensure effective communication regarding

treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, including Attachment C, CalOptima Policies, and Laws.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the friend or family member: (i) is requested by a Member; (ii) will not compromise the effectiveness of service; (iii) will not violate a Member's confidentiality; and (iv) Member is advised that an interpreter is available at no cost to the Member.

2.17. **CalOptima's Compliance Program and Other Guidance**. Provider and its employees, board members, owners, Contracted Providers, and Subcontractors furnishing services under this Contract ("**Provider Agents**") shall comply with the requirements of the Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Program and Code of Conduct available to Provider, and Provider shall make them available to Provider Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.18. **Equal Opportunity**. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. As applicable, Provider and its Subcontractors will comply with all provisions of and furnish and post all information and reports required by Section 503 of the Rehabilitation Act of 1973 (as amended), the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212), and of the Federal Executive Order No. 11246 (as amended), including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will permit access to their books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

If Provider or its Subcontractors do not comply with the provisions herein or with any applicable federal rules, regulations, or orders referenced herein, CalOptima may cancel, terminate, or suspend this Contract in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 (as amended), and such other sanctions and remedies provided under Laws.

Provider and its Subcontractors will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor or other Laws. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as directed by the Director of the Office of Federal Contract Compliance Programs or DHCS as a means of enforcing such provisions, including sanctions for noncompliance;

provided, however, that if Provider and its Subcontractors become involved in or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.19. **Reporting Obligations**. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services under this Contract as required by CalOptima, including to comply with the requests from Regulators.

2.20. **Subcontract Requirements**. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing, bind Subcontractors to all applicable provisions under this Contract, and incorporate all required provisions under this Contract or applicable Government Contracts. Provider shall process claims from and pay such Subcontractor for any Covered Services in compliance with the timeliness requirements set forth in Laws. Any Provider obligation under this Contract shall be deemed to include applicable Subcontractors. Provider shall make all Subcontracts available to CalOptima or its Regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include provisions requiring the Subcontractor to do the following:

2.20.1 Make all books and records related to this Contract available at all reasonable times for inspection, examination, or copying by CalOptima or Regulators in accordance with Government Contract requirements and Laws.

2.20.2 Maintain such books and records (i) in accordance with the general standards applicable to such books and records and any record requirements in this Contract, Laws, Government Contracts, or CalOptima Policies; and (ii) at the Subcontractor's place of business or at such other mutually agreeable location in the State.

2.20.3 Comply with all Laws with respect to providing Emergency Services.

2.20.4 Notify Provider of any investigations into Subcontractors' professional conduct or any suspension of or comment on a Subcontractor's Licenses, whether temporary or permanent.

2.20.5 Comply with the Compliance Program.

2.20.6 Comply with Member financial and hold harmless protections in this Contract and Laws.

2.21. **Fraud and Abuse Reporting**. Provider shall report to CalOptima all cases of suspected FWA, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services, whether the cases relate to Provider, Provider's employees, Subcontractors, Contracted Providers, and/or Members, within five (5) Business Days of the date when Provider first becomes aware of or is on notice of such activity.

2.22. **Participation Status**. Provider shall have policies and procedures in place to verify the Participation Status of Provider Agents. In addition, Provider represents and warrants that:

2.22.1 Provider and Provider Agents shall meet CalOptima's Participation Status requirements at all times during the Term.

2.22.2 Provider shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment from a State or federal program of Provider or Provider Agents occurring and/or discovered during the Term.

2.22.3 Provider shall take immediate action (i) to prevent any Provider's Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract to Members; and (ii) take any other actions required by Regulators, Government Contracts, and/or Laws.

2.22.4 Provider shall ensure the obligations of this Section 2.22 are included in Subcontracts.

2.22.5 CalOptima shall not make payment for an item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with Laws.

2.23. **Physical Access for Members.** Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**"), and Provider and its Subcontractors shall ensure access for the disabled, which includes compliance with the ramps, elevators, restrooms, designated parking spaces, and drinking water requirements under the ADA.

2.24. **CLIA Laboratories**. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number. Provider shall ensure those laboratories with certificates of waiver provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.25. **Member Rights**. Provider shall ensure that each Member's rights, as set forth in Laws, Government Contracts, and CalOptima Policies, are fully respected and observed. Provider will not retaliate or take any adverse action against a Member for exercising the Member's rights.

2.26. **Member Communication**.

2.26.1 Provider, acting within the scope of practice and Laws, shall freely communicate with Members, regardless of benefit coverage limitations, about (i) their health status, medical care, or treatment options, including alternative treatments; (ii) the risks, benefits, and consequences of treatment or non-treatment; and (iii) a Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Provider will not solicit or encourage Members to select another health plan.

2.26.2 Provider shall use best efforts to ensure that no employee, agent, Subcontractor, officer, director, or representative of Provider makes any derogatory remarks regarding CalOptima to any Member. Nothing in this section shall be interpreted to discourage or prohibit Provider from discussing treatment options with Members or providing other professional advice or treatment to Members deemed appropriate by Provider within Provider's scope of practice.

2.26.3 Provider shall not make any false statements or misrepresentations when communicating with Members.

2.27. **Electronic Transactions**. Provider shall participate in the exchange of electronic transactions with CalOptima, including electronic claims submission (EDI), verification of eligibility and enrollment through electronic means, and submission of electronic Authorization transactions in accordance with CalOptima Policies.

2.28. **Advance Directives**. If applicable, Provider shall maintain written policies and procedures related to Advance Directives and document patient records with respect to the existence of an Advance Directive in compliance with Laws. Provider shall not discriminate against any Member based on that Member's Advance Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.29. **WCM Program Compliance**. If Provider is a CCS-authorized provider, then in the provision of CCS Services to Members, Provider shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Provider will use evidence-based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.30. **CCS Provider Compliance**.

2.30.1 Only CCS-Paneled Providers may treat a Member's CCS Eligible Condition.

2.30.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the WCM Program in accordance with this Contract and CalOptima Policies.

2.30.2.1 Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.30.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given Members' CCS Eligible Condition.

2.31. **Subcontract Terminations**. If a Subcontract terminates, Provider shall ensure that there is no disruption in services provided to Members.

2.32. **Government Claims Act**. Subject to Section 9.13, Provider shall ensure that Provider and Provider Agents comply with the applicable provisions of the Government Claims Act (California Government Code §900 *et seq*.), including Government Code §§ 910 and 915, and CalOptima Policy AA.1217.

2.33. **Certification of Document and Data Submissions**. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract shall be accompanied by a certification statement on the Provider's letterhead, signed by Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to

sign for such officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information are accurate, complete, and truthful.

2.34. **CalOptima Oversight**. CalOptima is responsible for the monitoring and oversight of all obligations of Provider under this Contract, and CalOptima has the authority and responsibility to: (i) implement, maintain, and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections, and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Regulator determines that corrective action is needed with regard to any Provider duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima or its Regulators determine is necessary to comply with Laws, Government Contracts, Programs, Accreditation Organization standards, and/or CalOptima Policies.

2.35. **Conflicts of Interest**. Provider shall comply with all CalOptima requirements and Laws pertaining to conflicts of interest, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.), and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

2.35.1 Provider covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during their tenure has any interest, direct or indirect, in this Contract or the proceeds thereof, in accordance with 22 CCR § 53600(d). Provider further covenants that, for the Term, and consistent with the provisions of 22 CCR § 53600(f), no State officer or State employee shall be employed in a management or contractor position by Provider within one (1) year after the State office or State employee has terminated State employment.

2.35.2 Provider understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, Provider will not be entitled to any compensation for services performed pursuant to this Contract, and Provider will be required to reimburse CalOptima any sums paid to Provider. Provider further understands that Provider may be subject to criminal prosecution for a violation of California Government Code § 1090.

2.35.3 If Provider becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 2.35, Provider shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

2.36. **Hospital Referrals**. Provider shall refer Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

2.37. **Information and Cyber Security**. Provider must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

2.37.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Provider's information systems and any CalOptima information that Provider maintains or can access.

2.37.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Provider maintains or can access.

2.37.3 Security. Safeguards for the security of the information systems and CalOptima information that Provider maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

2.37.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

2.37.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

2.37.6 Notice. Provider shall notify CalOptima by email (or by telephone if Provider is unable to email CalOptima) within twenty four (24) hours of any use, disclosure, or access of Members' (i) protected health information (as that term is defined under 45 CFR § 160.103), (ii) personal information (as that term is defined under Civil Code § 1798.3(a), or (iii) medical information (as that term is defined under Civil Code § 56.05(j)) (collectively "**Protected Information**") that violates applicable laws and/or this Contract ("**Breach**").

2.37.7 Investigation. Provider shall immediately investigate the Breach and report the following to CalOptima as soon as reasonably practicable:

2.37.7.1 The Breach details, including the date of the Breach and when it was discovered;

2.37.7.2 The identification of each Member whose Protected Information was accessed, used, or disclosed during the Breach;

2.37.7.3 The nature of the data elements involved and the extent of the data involved in the Breach;

2.37.7.4 A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed Protected Information;

2.37.7.5 A description of where the Protected Information is believed to have been improperly transmitted or utilized;

2.37.7.6 A description of the probable causes of the Breach;

2.37.7.7 Whether a law enforcement official has requested a delay in notification of individuals of the Breach because such notification would impede a criminal investigation or damage national security; and

2.37.7.8 Whether any federal or State laws requiring notifying individuals of breaches were triggered.

For the purpose of this Section 2.37, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 3
CALOPTIMA OBLIGATIONS

3.1 **Service Authorization**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.2 **CalOptima Guidance**. CalOptima shall make available to Provider, on its website and upon request, all MOUs and CalOptima Policies applicable to Covered Services under this Contract.

3.3 **Member Eligibility**. CalOptima will maintain data on Member eligibility and enrollment and verify Member eligibility at the reasonable request of a Provider. CalOptima shall ensure Members are provided identification cards identifying Members as enrolled in the applicable Program. CalOptima shall ensure Members are provided identification cards identifying Members as enrolled in the applicable Program.

3.4 **Care Management**. CalOptima shall provide care management services for Members.

3.5 **Member Materials**. CalOptima shall furnish Provider any written materials that CalOptima wants Provider to provide to Members, including translations into threshold languages at the appropriate grade level.

ARTICLE 4
PAYMENT PROCEDURES

4.1 **Payment**. CalOptima shall pay Provider for Covered Services provided to Members as provided in CalOptima Policies and Attachment B. Provider agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Notwithstanding the foregoing, Provider may also collect other amounts (*e.g.*, SOCs and/or third-party liability payments) where expressly authorized under the Program(s) and Laws.

4.2 **Billing and Claims Submission**. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.3 **Prompt Payment**. CalOptima shall pay Provider in the time and manner set forth in Attachment B, CalOptima Policies, and Laws.

4.4 **Limitations of CalOptima's Payment Obligations**. Notwithstanding anything to the contrary in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the federal and/or State governments.

4.5 **Claim Completion and Accuracy**. Provider shall be responsible for the completion and accuracy of all Claims submitted (whether on paper forms or electronically), including Claims submitted for Provider by other parties. Use of a billing Agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone

who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.6 **Claims Deficiencies**. CalOptima shall deny any Claim that fails to meet CalOptima requirements for claims processing and notify Provider of the denial pursuant to CalOptima Policies and Laws.

4.7 **Coordination of Benefits**. Provider shall practice COB with other programs or entitlements, recognizing where CalOptima is not the primary coverage, in accordance with Program requirements and Laws. Provider acknowledges that Medi-Cal is the payer of last resort.

4.8 **Member Financial Protections**. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.8.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation from Members for Covered Services that are CalOptima's payment responsibility under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.8.2 In no event, including non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this Contract by CalOptima, shall Provider or any of its Subcontractors bill, seek compensation, collect reimbursement, or have any recourse against the State or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC if and to the extent required under the applicable Program and/or Laws.

4.8.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if Provider provides written notice to the Member prior to providing the services of what services are non-Covered Services and the cost of those non-Covered Services and the Member agrees to the payment in writing prior to the actual delivery of non-Covered Services. Provider must give a copy of such agreement to the Member and place in the Member's Medical Records prior to rendering such services.

4.8.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract or allowed under Laws, including reimbursing the Member for such a balance bill and deducting the reimbursement amount from any payments otherwise owed to Provider.

4.8.5 This Section 4.8 shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Provider shall ensure the substance of this Section 4.8 is included in all Subcontracts.

4.9 **Overpayments**. Provider must immediately report any Overpayment identified by Provider and repay such Overpayment to CalOptima within sixty (60) days of such identification by Provider or receipt of notice of an Overpayment identified by CalOptima or any other entity.

4.10 **Offset**. If CalOptima determines that an Overpayment has occurred, CalOptima shall have the right to recover such amounts from Provider by offset from current or future amounts due from CalOptima to Provider under this Contract or any other arrangement between the Parties, after

giving Provider notice and an opportunity to return/pay such amounts in accordance with Section 4.9 and the procedures, including the interest rates for untimely reimbursements, set forth in Health & Safety Code § 1371.1(a). This right to offset shall include:

4.10.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

4.10.2 Payments made for services provided to a Member who is subsequently determined to have not been eligible on the date of service.

4.10.3 Unpaid Conlan reimbursements owed by Provider to a Member.

4.10.4 Payments made for services provided by a provider that entered into a private contract with a Medicare beneficiary for Covered Services.

4.11. **Rate Adjustments**. CalOptima may adjust the payment rates under Attachment B during the Term to account for implementation of federal or State laws or regulations; changes in the State budget, Government Contract(s) or Regulators' policies; and/or changes in in the scope of Covered Services. CalOptima shall provide notice thereof to Provider as soon as practicable of any such changes, and such adjustments shall comply with Laws.

4.12. **Taxes and Contributions**. As applicable and required by Laws, Provider shall be responsible for withholding and paying all federal, State, and local taxes and contributions regarding (i) Provider's earnings under this Contract, (ii) the salaries or other benefits paid or made available to any persons retained or employed by Provider to furnish services under the Contract, or (iii) otherwise related to Provider's services under this Contract.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 **Indemnification**. Each Party agrees to defend, indemnify, and hold each other and the State harmless with respect to any claims, costs, damages and expenses, including reasonable attorneys' fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party of any functions, duties, or obligations of the Party under this Contract.

5.2 **Insurance**. Provider, prior to providing any services under this Contract, shall maintain, and ensure its Subcontractors maintain, insurance coverage and amounts as set forth in this Article 5 and Attachment A, in accordance with Laws and industry standards.

5.3 **Insurer Ratings**. Such insurance will be secured and maintained at Provider's own expense. All above insurance shall be provided by an insurer:

5.3.1 With an A.M. Best rating of A-VII or better; and

5.3.2 "Admitted" to do business in the State, an insurer approved to do business in the State by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers, or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.4 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned in this Article 5 are provided by a captive risk retention group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the captive risk retention group's or self-insured's audited financial statements and approves the waiver.

5.5 **Cancellation or Material Change**. Provider shall not of its own initiative cause such insurances as addressed in this Article 5 to be canceled or materially changed during the Term.

5.6 **Certificates of Insurance**. Prior to execution of this Contract, upon any change or renewal of insurance policies under this Article 5, or at CalOptima's request, Provider shall provide Certificates of Insurance to CalOptima showing the insurance coverage required under this Article 5 and further providing that (i) CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and (ii) coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.7 **Failure to Maintain Insurance**. If Provider fails or refuses to maintain or produce proof of the insurance required by this Article 5, CalOptima shall have the right, at its election, to terminate this Contract immediately upon written notice to Provider. Such termination shall not affect Provider's right to be paid for its time and materials expended prior to notification of termination.

ARTICLE 6
RECORDS, AUDITS, REPORTS, AND OTHER INFORMATION

6.1 **Access to and Audit of Contract Records**. Provider and its Subcontractors shall allow CalOptima, Regulators, and/or their duly authorized Agents and representatives access to books and records related to services provided under the Contract, including Medical Records, contracts, documents, and electronic systems. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit, and reproduce all records and materials and to verify Claims and reports submitted under this Contract. Provider shall maintain records in chronological sequence and in an immediately retrievable form in accordance with the Laws applicable to such record keeping. If a Regulator determines there is a reasonable possibility of fraud or similar risk, the Regulator may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, the Regulator reserves the right to suspend or terminate Provider and its Subcontractors from participation in the applicable Program; seek recovery of payments made to Provider; and impose other sanctions, and CalOptima may terminate this Contract immediately due to fraud.

6.2 **Medical Records**. As applicable to Covered Services, Provider and its Subcontractors shall establish and maintain, for each Member who has obtained Covered Services, Medical Records organized in a manner to contain such demographic and clinical information as necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with Laws, Program requirements, Government Contracts, and CalOptima Policies and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided and to permit peer review of the care furnished to the Member. In accordance with Laws, Provider shall provide copies of Medical Records to other treating or consulting providers (i) to facilitate a Member's continuity of care, including Member transfers;

(ii) when a Member seeks a second opinion on a diagnosis or treatment of a medical condition; or (iii) when such disclosure is necessary for a Member to access Medi-Cal or Medicare-covered services.

6.3 **Records Retention**. Provider shall maintain books and records in accordance with the time and manner requirements set forth in Laws and Programs, including as identified in Attachment D. When Provider furnishes Covered Services to a Member in more than one Program with different record retention periods, then the greater record retention requirement shall apply.

6.4 **Audit, Review, and/or Duplication**. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Laws concerning confidentiality and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 **Site Evaluations**. Provider shall permit CalOptima and Regulators to conduct periodic site evaluations, inspections, and onsite audits of Provider's facilities. CalOptima shall provide Provider five (5) Business Days' advance notice (or fewer if mutually agreed upon by the Parties) of any proposed site evaluation or inspection by CalOptima. If CalOptima or Regulators find any deficiencies in such facilities, Provider shall have thirty (30) days to correct such identified deficiencies, unless the Regulator requires that such deficiency be corrected within a shorter timeframe.

6.6 **Accreditation Surveys**. Provider shall cooperate with any surveys or evaluations relating to accreditation of CalOptima by any Accreditation Organization. Further, Provider agrees to implement any changes reasonably required as a result of all such Accreditation Organization surveys or evaluations.

6.7 **Confidentiality of Member Information**. Provider agrees to comply with Laws governing the confidentiality of Member medical and other information. Provider further agrees:

6.7.1 Privacy and Security Requirements. Provider shall comply with all Privacy Requirements. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with Privacy Requirements, including acceptance and generation of applicable electronic files in HIPAA-compliant standards formats.

6.7.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with Laws. Provider shall protect from unauthorized disclosure all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.8 **Confidentiality of CalOptima Information**.

6.8.1 During the Term, Provider may access confidential material or information ("**Confidential Information**") belonging to CalOptima. Confidential Information includes CalOptima's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like

circumstances would treat as confidential. CalOptima's Confidential Information also includes all user and patient information and clinical data that comes into CalOptima's possession or control. Provider may only use Confidential Information to fulfill its obligations under this Contract and related internal administrative purposes. Provider shall protect CalOptima's Confidential Information at all times in the same manner as Provider protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

6.8.2 For the purposes of Section 6.8, Confidential Information does not include information that: (i) is already known to Provider at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of Provider; (iii) is independently developed without use or benefit of CalOptima's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act (Government Code Section 7920.000 *et seq*.), applicable provisions of California Welfare and Institutions Code, or other state or federal laws.

6.8.3 Disclosure of the Confidential Information is restricted to Provider's Agents, who are bound by confidentiality obligations no less stringent than those in this Section 6.8, on a "need to know" basis in connection with the services performed under this Contract. Provider may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve Provider of its confidentiality obligations under this Section 6.8.

6.8.4 Provider shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of Provider. Those security procedures and other safeguards shall meet industry standards.

6.8.5 Upon written request of CalOptima, Provider shall promptly return to CalOptima or destroy all documents, notes, and other tangible materials containing CalOptima's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of Provider's information systems procedures, provided that Provider shall make no further use of such copies.

6.8.6 If Provider breaches its obligations under this Section 6.8, CalOptima shall entitled to such injunctive relief, without any requirement to prove actual monetary damage or post a bond or other security, and any and all other remedies available at law or in equity. This Section 6.8 in no way limits the liability or damages that may be assessed against Provider if Provider breaches this Section 6.8.

6.9 **Data Submission**. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports needed by CalOptima to meet its reporting requirements to Regulators, including DHCS and CMS, and as set forth in CalOptima Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 **Term**. The term of this Contract shall begin on the Effective Date and continue in effect for [insert years] (X) years ("**Initial Term**"). The Contract then shall automatically renew for [insert number] (X) one (1)-year terms (each a "**Renewal Term**"), unless otherwise terminated under this Article 7 or directed by CalOptima's Board of Directors. The Initial Term and any Renewal Terms together constitute the "**Term**" of this Contract.

7.2 **Termination for Breach**. CalOptima may, in its sole discretion, terminate this Contract if CalOptima determines that Provider or any Subcontractor (i) has failed to perform its contracted duties and responsibilities in a timely and proper manner, including the service procedures and standards identified in this Contract; (ii) has committed acts that discriminate against Members on the basis of their health status or requirements for health care services; (iii) has not provided Covered Services in the scope or manner required under this Contract; (iv) has engaged in prohibited marketing activities; (v) has failed to comply with the Compliance Program; or (vi) has materially breached any other covenant, condition, or term of this Contract (each a "**Termination for Breach**"). In the event of a Termination for Breach, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period, if the Termination for Breach is curable, in the sole discretion of CalOptima. If Provider does not cure the Termination for Breach within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Section 7.2 are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of the Contract breach by Provider or any Subcontractor.

7.3 **Termination for Non-Payment**. Provider may terminate the Contract if CalOptima fails to pay Provider for Covered Services, as required under the Contract ("**Non-Payment**"). In the event of Non-Payment, Provider shall give CalOptima prior written notice of its intent with a thirty (30)-day cure period. If CalOptima does not cure the Non-Payment within the thirty (30)-day cure period, Provider may terminate the Contract immediately following such thirty (30)-day period.

7.4 **Immediate Termination**. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice:

7.4.1 The suspension or revocation of any License required for Provider and/or Provider Agents to provide services under this Contract;

7.4.2 CalOptima's determination that the health, safety, or welfare of Members is jeopardized by continuation of this Contract;

7.4.3 The imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with Provider by any federal or state licensing agency;

7.4.4 Provider's failure to comply with Participation Status requirements;

7.4.5 Provider has committed FWA or permitted FWA in connection with Provider's obligations under the Contract;

7.4.6 CalOptima reasonably determines that Provider's facility, equipment, or personnel are insufficient to provide Covered Services;

7.4.7 Provider violates any Laws or is indicted;

7.4.8 Provider or its Contracted Providers fail to meet Minimum Standards and/or maintain the Licenses required to provide Covered Services;

7.4.9 Provider fails to satisfy the terms of a corrective action plan issued by CalOptima under this Contract;

7.4.10 Termination or non-renewal of any Government Contract;

7.4.11 Termination is required by a Regulator; or

7.4.12 The withdrawal of HHS's approval of the waiver granted to CalOptima under Section 1915(b) of the SSA. If CalOptima receives notice of termination from any Regulators or termination of the Section 1915(b) waiver, CalOptima shall immediately notify Provider.

7.5 **Termination for Insolvency**. If Provider, Provider's parent or holding company, or a Subcontractor becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, Provider shall immediately notify CalOptima, and CalOptima may immediately terminate the Contract at its sole option upon written notice to Hospital. In the event of the filing of a petition for bankruptcy by or against Provider, Provider's parent or holding company, or a principal Subcontractor, Provider shall ensure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract. If CalOptima becomes insolvent, Provider will have the right to terminate the Contract immediately upon written notice to CalOptima.

7.6 **Termination Without Cause**. [After the Initial Term] Either Party may terminate this Contract without cause upon [insert number of days] (XX) days' prior written notice to the other Party.

7.7 **Termination of Individual Provider**. If Provider is a group of licensed providers and grounds for termination of any individual provider arise pursuant to Sections 7.2 or 7.4, then CalOptima may, in its sole discretion, terminate only the participation of such individual provider under this Contract rather than the entire Contract.

7.8 **Obligations Upon Termination**. Upon termination of this Contract, Provider shall continue to provide Authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this Section 7.8 shall be at the contracted rates in effect under the Contract immediately prior to termination. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Regulators to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such Regulators, copies of any pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. For purposes of this section only, "under the care of Provider" shall mean that a Member has an Authorization from CalOptima to receive services from the Provider issued prior to the termination, all of the services Authorized have not yet been completed, and the time period covered by the Authorization has not yet expired. Termination shall not affect any rights or obligations hereunder that previously accrued or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Contract. The

provision of or payment for services after the termination of the Contract shall not be construed as a renewal of this Contract for any further term or a rescission of any Contract termination.

7.9 **Survival**. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 2.21 (Fraud and Abuse Reporting), 2.25 (Member Rights), 4.8 (Member Financial Protections), 4.9 (Overpayments), 4.10 (Offset), 4.12 (Taxes and Contributions), 5.1 (Indemnification), 6.1 (Access to and Audit of Contract Records), 6.3 (Records Retention), 6.4 (Audit, Review, and/or Duplication) 6.7 (Confidentiality of Member Information), 6.8 (Confidentiality of CalOptima Information), 6.9 (Data Submission), 7.8 (Obligations Upon Termination), 7.8 (Survival), Article 8 (Grievances and Appeals), 9.5 (Governing Law and Venue), 9.7 (No Liability of the County of Orange), 9.13 (Dispute Resolution), 9.14 (Interpretation), and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 **Provider Grievances**. CalOptima has established a fast and cost-effective system for provider complaints, grievances, and appeals in accordance with Laws, Government Contracts, and Program requirements ("**PDR System**"). Provider shall have access to this PDR System for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable Program. Provider shall attempt to resolve any complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract through the PDR System and exhaust all remedies under the PDR System prior to proceeding to arbitration under Section 9.13.

8.2 **Member Grievances and Appeals**. Provider agrees to cooperate in the investigation of any Member grievances, complaints, and appeals and be bound by CalOptima's decisions and, if applicable, State and/or federal hearing decisions or any subsequent appeals. Provider shall also continue providing services to a Member, if requested by CalOptima and the Member, until any grievance or appeal from a Member regarding Provider is resolved.

ARTICLE 9
GENERAL PROVISIONS

9.1 **Assignment, Assumption, and Change of Control**. Provider may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1, assignment includes: (i) the change of more than fifty percent (50%) of the directors or trustees of Provider; (ii) the merger, reorganization, or consolidation of Provider with another entity when Provider is not the surviving entity; or (iii) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (*e.g.,* the Board of Directors) to a third-party management person or entity. In addition, Provider must obtain CalOptima's prior written consent for any change of control. For purposes of this Section 9.1, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions).

9.2 **Entire Agreement**. This Contract, including its attachments, addenda, exhibits, and amendments and all CalOptima Policies applicable to Covered Services (and any amendments thereto), constitutes the entire agreement between the Parties and supersedes and terminates any previous agreements between the Parties. All prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this

Contract not expressly set forth herein shall be of no further force, effect, or legal consequence after the Effective Date.

9.3 **Amendments**. CalOptima reserves the right to amend or terminate the Contract at any time when such modifications or terminations are (i) mandated by changes in Laws; (ii) required by Government Contracts; or (iii) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall notify Provider in writing of such Regulatory Changes promptly and in accordance with applicable federal and/or State requirements, and Provider shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a Regulator, including DHCS. Notwithstanding a Regulatory Change, any other amendment of a term to this Contract must be in writing and executed by the Parties unless otherwise permitted or required by Laws.

9.4 **Force Majeure**. Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including an act of war, and excluding labor disputes. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

9.5 **Governing Law and Venue**. This Contract shall be governed by and construed in accordance with all laws of the State, federal laws, and regulations applicable to the Programs, and all contractual obligations of CalOptima. Subject to the restrictions in Section 9.13, Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

9.6 **Independent Contractor Relationship**. Provider and any Agents or employees of Provider in performance of this Contract shall act in an independent capacity and not as officers, employees, or Agents of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees and/or Agents of Provider, and CalOptima. Provider shall pay all wages, salaries, and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 **Names and Marks**. Provider shall not use the name, logo or other proprietary mark of CalOptima in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining CalOptima's express written approval of the material and consent to such use.

9.8 **No Liability of the County of Orange**. As required under County Ordinance No. 3896, as amended, the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County shall have no obligation or liability therefor.

9.9 **No Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in writing and signed and dated by the Parties.

9.10 **Notices**. Any notices required or permitted under this Contract shall be in writing and delivered to the addresses set forth below in this Section 9.10. Any notice not related to termination of this Contract may be sent electronically to the other Party's e-mail address listed in this section or such other address as may be provided by a Party to the other Party from time to time. If notice relates to termination of this Contract, such notice shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service that delivers to the noticed destination and provides proof of delivery to the sender. All notices sent to the addresses set forth in this section shall be effective (i) when first received by the Party, or (ii) upon refusal of delivery by the Party to which it was sent. Any Party whose address changes during the Term shall promptly notify the other Party in writing. If CalOptima cannot complete notice under this Section 9.9 because Provider's addresses are incorrect and/or Provider failed to notify CalOptima of the change, CalOptima shall provide notice under this Section 9.9, including for Contract termination, by making commercially reasonable efforts to deliver notice in any manner reasonably calculated to give Provider actual notice, and notice shall be deemed delivered upon the completion of those efforts.

If to CalOptima:

CalOptima
Attn: Director of Contracting
505 City Parkway West
Orange, CA 92868
[insert email]

If to Provider:

{{*Name on Notice_es_:signer1: }}
Name
{{*Title on Notice_es_:signer1: }}
Title
{{*Address on Notice_es_:signer1 }}
Address

9.11 **Prohibited Interests**. Provider covenants that, for the Term, no director, Member, officer, or employee of CalOptima during his/her tenure has any personal interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 **Authority to Execute**. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract, the Parties are formally bound. If Provider is comprised of a group of licensed providers, then the signatory warrants that they have the authority to bind each of the providers included in the Providers' roster, and Provider agrees that the provisions of this Contract bind all officers, members or employees of Provider who are similarly licensed and that such providers shall accept, as payment in full for the provision of Covered Services to Members, the reimbursement rates set forth in this Contract.

9.13 **Severability**. If any provision of this Contract is rendered invalid or unenforceable by Laws or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect as though the invalid or unenforceable parts had not been included herein.

9.14 **Dispute Resolution**.

9.14.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 9.14.2.

9.14.2 Arbitration. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.14.1, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties cannot agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning or to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive, exemplary, or treble damages. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

9.14.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.14.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes. Notwithstanding the foregoing, either Party may institute proceedings in a federal or state court of competent jurisdiction to seek temporary or preliminary injunctive relief to enforce the status quo in any dispute relating to this Contract pending the resolution of that dispute through arbitration.

9.14.4 Limitations Period. Provider acknowledges that Government Code § 911.2 requires a claim against a government entity to be brought no later than one (1) year after the accrual of the cause of action. As such, the Parties agree that arbitration under Section 9.14.2 must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or

should have been discovered with reasonable diligence; otherwise, the dispute will be deemed waived, and the complaining Party shall be barred from initiating arbitration or other proceedings related to the dispute, including any civil action in state or federal court. For disputes related to Claims, the one (1)-year limitations period under this Section 9.14.4 shall begin to run as of the final Claim denial date under CalOptima's provider appeals system. If Provider fails to participate in any portion of CalOptima's provider appeals system for a disputed Claim, as described in Section 8.1, Provider waives its right to arbitrate that claim. The deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

9.14.5 Waiver. By agreeing to binding arbitration as set forth in Section 9.14.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

9.15 **Injunctive Relief**. If Provider breaches any provision of this Contract, CalOptima shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Contract, including injunctive relief without the necessity of posting bond.

9.16 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Contract, and no implication shall be drawn against any Party by virtue of the drafting of this Contract.

9.17 **Without Limitation**. The words "include", "includes", and "including" are not words of limitation and shall be deemed to be followed by the phrase "without limitation".

9.18 **Recitals and Exhibits**. The recitals, attachments, exhibits, and/or addenda set forth in this Contract are made a part of the Contract by this reference.

ARTICLE 10
EXECUTION

10.1 **Execution**. This Contract may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument. Subject to the State and United States providing funding during the Term and for the purposes with respect to which it is entered into, execution of the Government Contracts, and the approval of the Contract by Regulators, this Contract shall become effective as of the Effective Date.

IN WITNESS WHEREOF, the Parties have executed this Contract as follows:

Provider **CalOptima**

{{_es_:signer1:signature}}

Signature
{{*Name_es_:signer1 }}
Print Name
{{*_es_:signer1:title }}
Title
{{*_es_:signer1:date }}
Date

{{_es_:signer2:signature}}

Signature
{{N_es_:signer2:fullname }}
Print Name
{{*_es_:signer2:title }}
Title
{{*_es_:signer2:date }}
Date

ATTACHMENT A
COVERED SERVICES

[*insert provider-specific exhibit*]

ATTACHMENT B
COMPENSATION

[*insert provider-specific exhibit*]

ATTACHMENT C
PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

1.1 **CalOptima Responsibilities**. CalOptima shall provide Members with face-to-face language and sign language interpretation services to ensure effective communication with providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth in this Attachment C.

1.2 **Request for Interpretation Services**. To request interpretation services for a Member, Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic ("**C&L**") Coordinator. CalOptima requires the following information at the time of the request:

1.2.1 Member name and ID, date of birth, and telephone number;

1.2.2 Name and phone number of the caretaker, if applicable;

1.2.3 Language or sign language needed;

1.2.4 Date and time of the appointment;

1.2.5 Address and telephone number of the facility where the appointment is to take place;

1.2.6 Estimated amount of time the interpretation service will be needed; and

1.2.7 Type of appointment: assessment, fitting/delivery, or other.

1.3 **C&L Coordinator**. CalOptima C&L Coordinator will make best efforts to secure an interpreter within seventy-two (72) hours of a request and will confirm the results of this effort to Provider and Member.

1.4 **Appointment Changes**. If there is any change with the appointment, Provider shall contact C&L Coordinator at least seventy-two (72) hours before the scheduled appointment.

1.5 **Provider Obligation for Cost**. If Provider fails to communicate with C&L Coordinator an interpretation request or change to an interpretation request more than seventy-two (72) hours before the appointment, Provider will incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 Health Network Contact. For Health Network Members, Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT D
Regulatory Requirements

The following additional terms and conditions contained in the following regulatory addenda apply to items and services furnished to Members under the Programs listed in Attachment A. If these terms conflict with those elsewhere in the Contract, the terms from the applicable addendum in this Attachment D shall control with respect to the Program at issue.

[*include the regulatory addendums for the Programs listed in Attachment A*]

Medi-Cal Program Addendum

This Medi-Cal Addendum shall apply to the Medi-Cal Program. For avoidance of doubt, this addendum does not apply to CalOptima's PACE, MSSP, or Covered California Programs; provided, however, OneCare members are eligible for Medicare and Medi-Cal benefits, and this addendum shall apply to dual eligible Members' Medi-Cal benefits.

1. **Definitions**.

1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Provider's and Subcontractor's duties and obligations under the Contract.

1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

1.3 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

1.4 "**HSC**" means the California Health & Safety Code.

1.5 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment D.

1.6 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws and government program requirements.

2. **Compliance with Laws**. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including the Knox Keene Act, HSC §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq*., 53900 *et seq*. Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Provider shall comply with all monitoring requirements of the Contract, the

DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. **Provider Data**. As applicable, Provider and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Provider shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. Provider will make corrections to provider data as requested by CalOptima. Provider data shall include all data required under the Contract – including reports and provider rosters. For purposes of this section, (1) "**Program Data**" means data that includes grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. **Encounter Data**. As applicable, Provider will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data needed by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Provider will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. **Reports**. Provider and its Subcontractors agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. **California Health and Human Services ("CalHHS") Data Exchange**. Provider shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"); (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [HSC § 130290; DHCS Contract, Exhibit A, Attachment III § 3.1.5(A)(21), (B)(30)]

7. **Additional Subcontracting Requirements**. If Provider is allowed to subcontract services under this Contract and does so subcontract, then Provider shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

    7.1 Subcontracts for Provision of Covered Services. Provider shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. Provider will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

    7.2 Subcontracts. Provider shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

        7.2.1 The services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination,

and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor per unit of service.

7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 29, *Amendment and Termination*; Section 30, *Delegated Activities*; Section 31, *Utilization Data*; Section 60, *DHCS Beneficiary*; and any other section of this Attachment D that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. **Records Retention**. Provider and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State and pursuant to HSC § 1381(b). Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima and/or representatives of any regulatory or law enforcement agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4.D, 3.1.5(A.9) and (B.14); HSC § 1381; 28 CCR 1300.81]

9. **Access to Books and Records**. Provider agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily

entitled to have oversight responsibilities over CalOptima and/or Provider and its Subcontractors; (ii) at all reasonable times at Provider's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Provider, CalOptima reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; immediately suspend payments to Provider; seek recovery of payments made to Provider or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

As permitted under Laws, Provider and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by Regulators including DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

This provision shall survive the expiration or termination of this Contract and Subcontracts. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5 (A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Provider agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time is of the essence in responding to such requests. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Provider or its Subcontractors related to this Contract or Subcontracts. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. **Transfer**. Provider agrees and will require its Subcontractors to assist CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. **Unsatisfactory Performance**. Provider agrees that the Contract or Provider's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that Provider has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. **Hold Harmless**. Provider and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services. Provider and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Provider pursuant to this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. **Prohibition on Member Claims and Member Billing**. Provider and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Provider and its Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14); 3.3.6; 5.2.7]

15. **Prospective Requirements**. CalOptima will inform Provider of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Provider's obligations before the requirement becomes effective. Provider agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by CalOptima or DHCS. Provider will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective; and (ii) agree to comply with new requirements within thirty (30) days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. **Network Provider Training**. Provider shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Provider shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Provider shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24); 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. Provider shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to Provider with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

17. **Language Assistance and Interpreter Services**. Provider and its Subcontractors will comply with language assistance standards developed pursuant to HSC § 1367.04 and the DHCS Contract. Provider agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25); 5.1.3(F)]

18. **Fraud, Waste, and Abuse Reporting**. Provider shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. Provider agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and

reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Provider information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Provider acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26),]

19. **Provider Identified Overpayments**. In addition to Overpayment requirements under the Contract, Provider shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date Provider identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19) and (B.27)]

20. **Health Care Providers' Bill of Rights**. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in HSC § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. **Provider Grievances**. Provider has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to HSC §1367(h)(1). CalOptima's process to resolve Provider disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. **Effective Dates**. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. **Assignment and Sub-delegation**. Provider agrees that any assignment or delegation of an obligation or responsibility under this Contract by Provider to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Provider further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. **Quality Improvement & Utilization Management**. Provider agrees to cooperate and participate in CalOptima's quality management and improvement programs, including participating in the UM program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. **Emergency Services and Post-Stabilization Delegation**. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Provider under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)].

26. **Telehealth**. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Provider shall ensure that it complies with all applicable statutory and regulatory requirements, including HSC § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does

not have to independently contact a different provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable under the Contract if Provider did not comply with these Telehealth Requirements.

27. **Electronic Prescriptions**. Provider and any Subcontractors who may issue prescriptions under Business & Professions Code § 4040(a) shall have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. **Amendment and Termination**. Provider agrees that CalOptima shall notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. **Delegated Activities**. If Provider is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, Claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Provider, to the extent agreed upon between CalOptima and Provider. Provider agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Provider agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Provider has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Provider; (ii) CalOptima's oversight, monitoring, and evaluation processes and Provider's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Provider's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. **Utilization Data**. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. **Medical Decisions**. Provider will ensure that medical decisions or any course of treatment in the provision of Covered Services by Provider, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. **Capacity, Licensure, and Enrollment**. Provider and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Provider and Subcontractor is authorized to provide under this Contract, consistent with the scope of Provider's and/or

Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. Provider and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Provider warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require its Subcontractors to maintain adequate staff as well. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. **Medi-Cal Enrollment**. If Provider is a provider type that is not able to enroll in Medi-Cal through the DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35.

34. **Prohibition Against Payment to Excluded Providers**. Provider agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Provider if Provider is excluded from State or federal programs. Provider further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. **Ownership Disclosure Statement**. Prior to commencing services under this Contract, Provider shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Provider holding more than five percent (5%) of the stock issued by Provider, and major creditors holding more than five percent (5%) of the debt of Provider by accurately completing the Disclosure Form provided by CalOptima and included in CalOptima Policy EE.1141. Provider shall promptly notify CalOptima whenever changes occur to the information provided in the Disclosure Form in accordance with this Contract and CalOptima Policy EE.1141. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    36.1 If a Subcontractor is not eligible to enroll in Medi-Cal, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35 for the Subcontractor.

36. **Performance Improvement Projects**. Provider and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. **No Punitive Action**. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. **Claims Processing**. CalOptima will process Claims in accordance with the DHCS Contract, HSC §§ 1371 through 1371.36 and their implementing regulations, and as outlined in CalOptima Policies. If Provider is responsible for Claims payments, Provider will pay Claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

39. **Cost Avoidance/Other Health Coverage**. Provider acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay Claims for services provided to a Member who has third-party coverage without proof that Provider has first exhausted all other payment sources. Provider shall not refuse to provide Covered Services to Members when third-party coverage is indicated in the Member's Medi-Cal eligibility record. Provider shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Provider must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. **Public Record**. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. **Provider Preventable Condition**. CalOptima will not pay Provider for a provider preventable condition as described in 42 C.F.R. § 438.3(g). As a condition of payment, Provider shall comply with reporting requirements on provider preventable conditions in the form and frequency required by DHCS in APL 17-009 or any superseding APL. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. **Member Rights**. Provider and Subcontractors will not retaliate or take any adverse action against a Member for the Member exercising their rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. **Medical Records**. All medical records shall be maintained in accordance with CalOptima Policies. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. **Timely Access/Standards of Accessibility**. Provider and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Provider and Subcontractors will comply with CalOptima's procedures for monitoring Provider's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. **Minor Consent Services**. Provider and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Provider and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. **Emergency Preparedness Requirements**. Provider agrees to cooperate with and comply with CalOptima's Emergency requirements, policies and procedures, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Provider

will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Provider's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

47. **State's Right to Monitor**. Provider and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Provider, Subcontractor, and Provider's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. **Laboratory Testing**. Provider agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. **Third Party Tort Liability**. Provider and Subcontractors shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) days of discovery, which shall in turn notify DHCS, of any action by the Member that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. **Changes in Availability or Location of Services**. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [DHCS Contract, Exhibit A, Attachment III, § 5.2.9]

51. **Confidentiality of Medi-Cal Members**.

52.1 Provider and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq*. Provider and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

52.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, Provider and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Provider and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

52.2.1 Provider and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider may release medical records in accordance with Laws pertaining to the release of this type of information. Provider is not required to report requests for medical records made in accordance with Laws.

52.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

52.2.3 For purposes of this Section 52.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. **Debarment Certification**. By signing this Contract, Provider agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

53.1 By signing this Contract, Provider certifies to the best of its knowledge and belief, that it and its principals:

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

53.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

53.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 53.1.2, above;

53.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

53.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

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

53.1.7 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

53.2 If the Provider is unable to certify to any of the statements in this Section 53, Provider shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

53.3 The terms and definitions in this Section 53 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

53.4 If the Provider knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. **DHCS Directions**. If required by DHCS, Provider and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34]

54. **Lobbying Restrictions and Disclosure Certification**.

55.1 This Section 55 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 55 is applicable to the Contract, Provider shall comply with the requirements in this Section 55, as well as complete the disclosure forms in Attachment E prior to the Effective Date.

55.2 Certification and Disclosure Requirements.

55.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Provider shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

55.2.2 Provider shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Provider has made

or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 55.3 if paid for with appropriated funds.

55.2.3 Provider shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Provider under Section 55.2.2. An event that materially affects the accuracy of the information reported includes:

55.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

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

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

55.2.4 Each Subcontractor who requests or receives from Provider or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

55.2.5 All disclosure forms (but not certifications) completed under this Section 55.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

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

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Provider agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 et seq.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. **Smoke-Free Workplace**. Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of

eighteen (18), if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Provider shall comply with the applicable requirements of the Pro-Children Act. Provider further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. **Domestic Partners**. Pursuant to HSC § 1261, if Provider is licensed pursuant to HSC § 1250, Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [HSC § 1261]

58. **Conflict of Interest**. Provider agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict-of-interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) Business Days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. **DHCS Beneficiary**. Provider expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. **Employment Non-Discrimination**. During the performance of this Contract, neither Provider nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Provider shall include the non-discrimination and compliance provisions of this Section 61 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

61.1 Provider and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and

federal implementing regulations promulgated under the above-listed statutes. Provider and all Subcontractors shall comply with California nondiscrimination requirements, including the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code § 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. **Member Non-Discrimination**. Neither Provider nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

62.1 Provider shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 62, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

62.2 Provider shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

62.3 Provider shall require all Subcontractors to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E § 1.1.30]

62. **Program Integrity and Compliance Program**. Provider will comply with CalOptima's program integrity and compliance program. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. **Federally Qualified Health Centers ("FQHC"), Rural Health Centers ("RHC"), or Indian Health Services ("IHS") Facility**.

64.1 If Provider is an FQHC or an RHC, Provider will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including: (i) submitting documentation of services provided, reimbursement level, and payment amounts; (ii) certifying that this Contract is offered to Provider on the same terms and conditions as those offered to other network providers providing similar services and that reimbursement is not less than the level and amount of payment which the entity would make for the service if they were furnished by a provider that is not an FQHC; and (iii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

64.2 63.2 If Provider is an FQHC or an RHC, Provider acknowledges and agrees that CalOptima is not required to pay Provider the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that Provider and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

64.3 63.3 To the extent Provider is an Indian Health Services facility that qualifies as an FQHC and RHC; Provider agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to Provider.

64.4 63.4 If Provider is an Indian Health Services provider, CalOptima shall comply with all applicable provisions of DHCS APL 24-002, including any successor guidance, ("**APL 24-002**") and the Laws referenced therein, and if any other provision of this Contract conflicts with APL 24-002, the provisions of DHCS APL 24-002 shall control and supersede the conflicting provisions of this Contract.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

64. **Lead Screening**. If Provider is a school-based mental health and substance use disorder provider, Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with 17 CCR §§ 37000-37100 and applicable APLs. As applicable, Provider will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, §5.3.4(D)]

OneCare Program Addendum

This OneCare Addendum shall only apply to the OneCare Program. For avoidance of doubt, this addendum

does not apply to CalOptima's Medi-Cal, PACE, MSSP, or Covered California Programs; provided, however, OneCare members are eligible for Medicare and Medi-Cal benefits, and this addendum shall apply to dual eligible Members' Medicare benefits.

1. **Hold Harmless**. Provider agrees to hold harmless Members in case CalOptima cannot or will not pay for services under the Contract. This provision shall not prohibit collection of any applicable SOC billed in accordance with the terms of Members' evidence of coverage. Provider further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of Members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Provider and Members or persons acting on their behalf that relates to liability for payment for Covered Services.

2. **Accountability**. Any services or other activity under the Contract performed by Provider and any of its Subcontractors will be performed in accordance with CalOptima's contractual obligations to CMS and DHCS, including the requirements at 42 C.F.R. § 438.414 in relation to the grievance system.

3. **Coordination of Benefits Requirements**. Provider shall coordinate with CalOptima for proper determination of COB. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their Claims payment procedures, individuals and services for which there may be a financially responsible party other than Medicare and the OneCare Program. Provider will bill and collect from other payers and third-party liens such amounts for Covered Services for which the other payer is responsible.

4. **Submission and Prompt Payment of Claims**. Provider agrees to submit Claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny Claims that are not submitted within ninety (90) days of the date of service. CalOptima shall provide payment to Provider within forty-five (45) Business Days of CalOptima's receipt of a Clean Claim from Provider, or CalOptima will contest or deny Provider's Claim within forty-five (45) Business Days following CalOptima's receipt thereof.

5. **Claims Payment**. CalOptima will not pay Provider for a provider preventable condition. As a condition of payment, Provider will comply with the applicable reporting requirements on provider preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by CalOptima or DHCS. Provider shall comply with such reporting requirements to the extent that Provider directly furnishes services.

6. **Cost-Sharing**. Provider agrees that Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members. Provider and any of its contracted providers must not impose cost-sharing requirements on Members that would exceed the amounts permitted under the Medi-Cal Program, 42 U.S.C. § 1395w-22(a)(7), and 42 C.F.R. section 422.504(g)(1)(iii). Provider shall (i) accept reimbursement from CalOptima under the Contract as payment in full for services rendered to Members; or (ii) bill Member's Medi-Cal managed care health plan, as applicable and in accordance with Laws, for any additional Medicare payments that may be reimbursed by Medi-Cal. Provider will also comply with requirements outlined in W&I Code § 14019.4 related to Medi-Cal services.

7. **Federal Funds**. Provider acknowledges that payments Provider receives from CalOptima are, in whole or part, from federal funds. Therefore, Provider and any of its Subcontractors are subject to

certain laws that are applicable to individuals and entities receiving federal funds, which may include Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the ADA; Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, and any other regulations applicable to recipients of federal funds.

8. **Compliance with Medicare Laws**. Provider will comply with all applicable federal and State laws (including Medicare laws), regulations, and CMS instructions, including laws and regulations designed to prevent or ameliorate FWA, including applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 *et seq*.), and the anti-kickback statute (Section 1128(B)(b) of the Social Security Act), and HIPAA administrative simplification rules at 45 C.F.R. Parts 160, 162 and 164. Further, Provider agrees that any services provided by Provider will be consistent with and will comply with CalOptima's contract with CMS ("**CMS Contract**").

9. **Language Assistance**. Provider will provide services in a culturally competent manner and agrees to arrange for the provision of interpreter services for Members at all Provider sites.

10. **Reporting**. Provider agrees to provide relevant reports, data, and information necessary for CalOptima to meet its obligations under the OneCare Program and Laws, including 42 CFR §§ 422.516 and 422.310. In addition, Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) Business Days of the date when Provider first becomes aware of or is on notice of such activity.

11. **Offshore Activities**. Unless CalOptima has provided prior written authorization, all services provided by Provider pursuant to the Contract must be performed within the United States, the District of Columbia, or the United States territories.

12. **Excluded Individuals/Program Integrity**. Provider acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to the Contract with any individual or entity (hereafter, "**Person**") whom Provider knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the SSA. Provider hereby certifies that no such excluded Person currently is employed by or under contract with Provider. Provider shall ensure that the Persons it employs or contracts for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, as defined in 42 CFR § 422.2. Provider shall promptly after discovery disclose to CalOptima any exclusion, or other event that makes a Provider employee or downstream entity ineligible to perform work related to federal health care programs, in accordance with 42 CFR § 422.752(a)(8). Provider agrees to be bound by the provisions set forth at 2 CFR Part 376.

13. **Emergency Medical Treatment and Labor Act**. Provider must comply with the federal Emergency Medical Treatment and Labor Act ("**EMTALA**"), as applicable, and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

14. **Punitive Action**. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution or supports a Member's appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information a Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for a Member's right to participate in

decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

15. **Indemnity**. Provider is not required to indemnify CalOptima for any expenses and liabilities, including judgments, settlements, attorney's fees, court costs, and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, other policies, guidelines, or actions.

MSSP Program Addendum

This MSSP Addendum shall only apply to the MSSP Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, Medicare, PACE, or Covered California Programs.

1. **MSSP Site Manual**. Provider shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA Medi-Cal Services Branch, including any subsequent changes to applicable laws. The MSSP Site Manual, dated July 1, 1992, is produced by the CDA and includes all subsequent amendments.

2. **Provider Confidentiality Statement**. Provider shall sign and return a Contractor/Vendor Confidentiality Statement (CDA 1024 Form) with the Contract to ensure that Provider is aware of, and agrees to comply with, its obligations to protect CDA information and assets from unauthorized access and disclosure.

3. **Travel Reimbursement Limits**. If the Contract provides for the reimbursement of authorized travel, any reimbursement for such authorized travel shall be at a rate not to exceed those amounts paid by the State in accordance with the Department of Personnel Administration's rules and regulations, which may be found at http://www.dpa.ca.gov/textdocs/freepmls/PML2008019.pdf (generally), http://www.dpa.ca.gov/personnel-policies/travel/meals-and-incidentals.htm (per diem), and http://www.dpa.ca.gov/personnel-policies/travel/short-term-travel.htm (lodging). This is not to be construed as limiting Provider from paying any differences in costs, from funds not derived from MSSP, between the Department of Personnel Administration rates and any rates Provider is obligated to pay under other contractual agreements. No travel outside of the State shall be reimbursed, unless prior written authorization from the State is obtained (2 CCR § 599.615 *et seq*.).

4. **Records**. Provider shall maintain complete records, including accounting records, contracts, agreements, and insurance documentation, pertaining to its activities and expenditures hereunder in a form satisfactory to CDA and in accordance with this Contract, and Provider shall make all records pertaining to the Contract available for inspection and audit by CalOptima and the State, or either's duly authorized agents, at any time during normal business hours. All such records must be maintained and made available by the Provider; (i) until an audit has occurred and an audit resolution has been issued, or unless otherwise authorized in writing by CDA or DHCS's Audit Branch; (ii) for such longer period, if any, as is required by applicable statue, by any other clause of the Contract; or (iii) for such longer period as CDA deems necessary.

PACE Program Addendum

This PACE Program Addendum shall only apply to the PACE Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, MSSP, or Covered California Programs.

1. **Definitions**. PACE is a program that features a comprehensive medical and social services delivery system using an interdisciplinary team ("**IDT**") approach in an adult day health center that is

supplemented by in-home and referral services, in accordance with Members' needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of Members and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima. PACE services shall include the following:

1.1 All Medicare-covered items and services;

1.2 All Medi-Cal-covered items and services; and

1.3 Other services determined necessary by the IDT to improve and maintain the Members' overall health statuses.

2. **State Termination**.

2.1 CalOptima may terminate the Contract as it applies to providing services to Members if CalOptima's PACE Agreement or DHCS Contract with DHCS terminates for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or DHCS Contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS or CMS, or the DHCS Contract from DHCS.

3. **Provider Responsibilities**.

3.1 Service Area. Provider shall make PACE services available at a location accessible to Members within Orange County, California.

3.2 Services Authorized. Provider shall furnish only those services Authorized by the CalOptima PACE IDT. A primary care provider referral is deemed an IDT Authorization.

3.3 Interdisciplinary Team Meeting Participation. If necessary for the benefit of Member care delivery or planning, Provider shall participate in CalOptima PACE IDT meetings. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

3.4 Payment in Full. Provider shall accept CalOptima's payment as payment in full for services provided to Members and shall not seek any reimbursement for services directly from Members, Medi-Cal, Medicare, or another insurance carrier or provider. Provider shall not seek any type of cost-share amount from Members for PACE Covered Services. Members shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against Members to collect sums that are owed by CalOptima. Surcharges to Members by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Provider shall reimburse Members as appropriate.

3.5 Hold Harmless. Provider will not bill the State, CMS, or Members if CalOptima does not pay for services performed by Provider pursuant to the Contract.

3.6 Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and HHS as may be necessary for compliance by CalOptima with its statutory obligations and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

3.7 Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under the Contract, such physician/provider shall (a) accept payment from Provider as full payment for services delivered to Members, (b) comply with the applicable provisions of the Contract, (c) only bill services to Provider, unless Provider has made other billing arrangements with CalOptima, (d) not bill Members under any circumstances, and (e) cooperate with and participate in CalOptima's quality assurance and improvement program.

3.8 Compliance with the Law. Provider shall comply with the applicable provisions of 42 CFR Part 460, including 42 CFR § 460.70.

4. **Provider Personnel**.

4.1. Provider shall ensure its employees and Contracted Providers providing direct patient care to PACE Members comply with all State and federal requirements for direct patient care staff in their respective setting, including:

4.1.1 Having not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or social service programs under Title XX of the SSA;

4.1.2 Not a pose any potential risk to Members because of conviction or physical, sexual, drug or alcohol abuse;

4.1.3 Be free of communicable diseases; and

4.1.4 Agree to abide by the requirements, philosophy, practices and protocols of CalOptima's PACE Program and 22 CCR § 78413.

4.2. Provider shall provide documentation within one (1) Business Day to CalOptima, upon request, a list of all Contracted Providers and Provider personnel employed during the requested period, including first and last name, job title, date of hire, date of termination (if terminated within the requested period), type of employment (full-time, part-time, volunteer, or other), and whether the position required a license.

4.3. Provider shall ensure its records contain the following for each employee:

4.3.1 An employment application, a full name, social security number, date of employment, date of birth, home address, educational background, and previous employment experience, including dates employed.

4.3.2 Proof that each employee received in-service training in first aid and in cardiopulmonary resuscitation within the first six (6) months of employment.

4.3.3 A background check completed prior to the employee's date of hire.

4.3.4 An OIG exclusion check completed prior to their date of hire.

4.3.5 Documentation that each employee has current and active licensure if licensure is required for their position.

4.3.6 A chest x-ray or test for tuberculosis infection for each employee, as recommended by the federal Centers for Disease Control and Prevention and licensed by the federal Food and Drug Administration, performed not more than twelve (12) months prior to employment or within seven (7) days of employment.

4.3.7 A health examination signed by the examining physician or person lawfully authorized to perform such examination which indicates the employee is physically qualified to perform duties, is free from any condition that would create a hazard to self or others, and medically cleared of communicable diseases before engaging in direct Member contact.

4.3.8 Documentation that each employee completed the following CalOptima trainings:

4.3.8.1 Orientation to the PACE Program, including the Member Bill of Rights, service determination requests, and the grievance and appeals processes.

4.3.8.2 Skills competencies completed both ***before*** providing any independent care to Members, as well as annually.

4.4. Provider shall have written policies implementing the requirements of this Section 4 and retain employee records pertaining to this Section 4 for at least three (3) years following termination of each employee's employment.

5. **PACE Liaison**. CalOptima PACE Program director or their designee shall be designated as the liaison to coordinate activities between Provider and CalOptima.

6. **Records**. Provider shall retain PACE Program records for the latter of (a) ten (10) years from the final date of the DHCS Contract or the date of completion of any audit; or (b) ten (10) years from the close of the current fiscal year in which the service occurred, in which the record or data was created or applied, and for which the financial record was created, unless a longer period is required by Laws.

This provision shall survive the expiration or termination of the Contract, whether with or without cause, by rescission, or otherwise.

7. **Assignment and Delegation**. The Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima.

8. **Third Party Tort Liability/Estate Recovery**. Provider shall make no claim for the recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third-party liability claims and provide information relative to potential third-party liability claims, in accordance with CalOptima Policies.

9. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Provider shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its

subcontractors' possession relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (a) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (b) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its subcontractors related to the Contract or subcontracts.

10. **DHCS Policies**. Covered Services provided under the Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Integrated Systems of Care Division ("**ISCD**") (or any successor division to the ISCD).

11. **DHCS Directions**. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

12. **Turnover and Phase-Out Requirement**. Provider agrees that, upon termination of the DHCS Contract between CalOptima and DHCS, provider shall make available to CalOptima and DHCS copies of Medical Records, Member files, and any other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. Provider further agrees to assist CalOptima with phase-out for the DHCS Contract, which consists of the resolution of all financial and reporting obligations of CalOptima.

13. **Reporting Unusual Incidents or Occurrences**. Provider shall report to CalOptima within twenty four (24) hours any unusual incidents, injuries, or occurrences of which Provider becomes aware relating to Members. For purposes of this section, an unusual incident or injury is one that threatens the welfare, safety or health of any Member and that is not consistent with Provider's routine operation or patient care practices, including a fire, explosion, epidemic outbreak, poisoning, catastrophe, major accident, or like event that occurs in or on the premises of Provider's office or facility which threatens welfare, safety or health of Members.

14. **Emergency Services and Post-Stabilization Delegation**. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Provider under the Contract.

15. **DHCS Monitoring**. Provider shall comply with all monitoring provisions in CalOptima's contract with DHCS and any monitoring requests by DHCS.

Covered California Program Addendum

This Covered California Addendum shall only apply to the Covered California Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, MSSP, or PACE Programs.

1. **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Covered California Program Addendum.

1.1. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("**QHP**") issuer to provide administrative services or health care services to qualified individuals and their dependents.

1.2. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

1.3. **Emergency Medical Condition** means the same as the definition of "emergency medical condition" set forth in HSC § 1317.1(b).

1.4. **Emergency Services** means those Covered Services for inpatient and outpatient care services, as specified in HSC § 1317.1(a), furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize a Member's Emergency Medical Condition.

1.5. **Medically Necessary** and **Medical Necessity** means the reasonable and necessary Covered Services needed to prevent, diagnoses, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

2. **Compliance.** Provider agrees to be bound by all provisions of the Qualified Health Plan Issuer Contract between CalOptima and Covered California ("**QHP Contract**") that are applicable to the services Provider provides to CalOptima and its Members. Provider agrees to comply with all Laws, including the federal Patient Protection and Affordable Care Act, (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), known collectively as the Affordable Care Act; the California Patient Protection and Affordable Care Act, Assembly Bill 1602 and Senate Bill 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010); the Americans with Disabilities Act of 1990 (42 USC §§ 12101 *et seq*.); the Anti-Kickback Statute (42 USC § 1320a–7b); the Public Contracts Anti-Kickback Act (41 USC §§ 51 *et seq*.); the Stark Law (42 USC § 1395nn); the Knox- Keene Health Care Service Plan Act of 1975 (HSC §§ 1340 *et seq*.); the Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq*.); all Laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code); Public Contract Code Section 10295.3 with regard to benefits for domestic partners; environmental laws, rules, and regulations applicable to its operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30 (commencing with Section 42460 of the Public Resources Code) relating to hazardous and solid waste; and any and all other State and federal Laws, rules, and regulations applicable to the operation of Covered California, the QHP Contract, and Provider's provision of services under the Contract. Provider will incorporate such applicable requirements in Provider's contracts with its Subcontractors, including the provisions under §4.4.1(d) of the QHP Contract. [QHP Contract §§ 1.2(c), 1.3(b), 1.13, 4.4.1(b)-(d)]

3. **Nondiscrimination in Administration of Services and Benefits.** Provider and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557 (42 USC § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d *et seq*.), Title IX of the Education Amendments of 1972 (20 USC §§ 1681 *et seq*.), the Age Discrimination Act of 1975 (42 USC §§ 6101 *et seq*.), Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), or subject to any other applicable Laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health Product or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xv), 1.10(a)]

4. **Conflict of Interest.** Provider agrees to be free from any conflicts of interest with respect to Covered Services provided under the Contract. Provider and its personnel shall not currently have, and shall not have throughout the Term, any direct interest that may present a conflict in any manner with the performance of services required under the Contract. Provider represents that it is not aware of any conflict of interest or any basis for potential violations with respect to Laws that govern referrals required for the provision of certain Covered Services, including federal and State Anti-Kickback and Anti-Self-Referral Laws. [QHP §§ 4.4.1(d)(xvi), 1.11]

5. **Nondiscrimination in Workplace.** Provider and its agents, employees, and Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome, mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), aged forty (40) or over, marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Provider and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Provider and its agents and employees shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 10000 *et seq*.). The applicable regulations of the California Fair Employment and Housing Commission implementing Government Code § 12900, set forth in California Code of Regulations Chapter 5 of Division 4 of Title 2, including 2 CCR §§ 11102 *et seq*., are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]

6. **Privacy and Security Requirements for Personally Identifiable Data.** Provider agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 USC §§ 1320d *et seq*., HITECH, and any current and future regulations promulgated under HIPAA or HITECH, all as amended from time to time and collectively referred to herein as the "**HIPAA Requirements**." Provider agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this section that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(a); 45 CFR § 155.260(b)(2)(v)]

   6.1. Provider shall, and shall require that its Subcontractors, maintain technology policies and procedures acceptable to CalOptima that provide reasonable safeguards to protect Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Provider and its Subcontractors. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(e)]

   6.2. Provider shall, and shall require that its Subcontractors, comply with all applicable Exchange Protection of Information policies, in accordance with the terms and conditions set forth in Section 10.2 of the QHP Contract, Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(h), 10.2]

   6.3. If Provider will have access to Protected Health Information and/or Personally Identifiable Information that is received from, created, or received by CalOptima on behalf of Covered California or in connection with the QHP Contract, Provider agrees to be bound by the same or more stringent restrictions, terms, and conditions as those that apply to CalOptima pursuant to the QHP Contract with respect to such Protected Health Information and Personally

Identifiable Information, provided, however, that any restrictions that are more stringent shall be set forth in the Contract. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(i)]

6.4. Provider shall mitigate to the extent practicable, any harmful effect that is known to Provider of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(f)]

6.5. Provider shall cooperate with Covered California in investigating any Breach and/or successful Security Incident involving Protected Health Information and/or Personally Identifiable Information and in meeting Covered California's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving Protected Health Information and/or Personally Identifiable Information is attributable to Provider, Provider shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and CalOptima. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(e)(iii)]

6.6. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of CalOptima, Provider agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR Part 162. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(iv)]

6.7. Provider shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider or its Subcontractors or agents, including (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) State law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of the Breach and to respond to the Breach; (b) mitigate harm to the affected Individual(s); and (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(vi)]

7. **State Agency Reviews**. Provider agrees that Covered California, the California Department of General Services, State Auditors, other State and federal regulatory agencies, or their designated representatives shall, subject to applicable Laws regarding the confidentiality and release of Protected Heath Information of Members, have the right to review and to copy any records and supporting documentation pertaining to the performance of the QHP Contract. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(xxii), 11.5(c)]

8. **Performance Measurement Standards.** Provider shall comply with all QHP Contract requirements and performance measurement standards, including those related to customer service that are applicable to Covered Services. CalOptima shall provide the performance measurement standards to Provider. CalOptima may impose penalties for failure to comply or otherwise act in accordance with applicable performance standards of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xix), Article 7]

9. **Medical Records.** Except with respect to any longer periods that may be required under Laws, Provider will maintain a Medical Record documentation system adequate to fully disclose and document the medical condition of each Member, to the extent applicable to the services, and the extent of Covered Services provided to each Member by Provider. Medical Records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by Laws, if an audit, litigation, research, evaluation, claim, or other action involving records has not concluded before the end of the seven (7)-year minimum retention period, Provider shall retain the Medical Records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(i) & (xxii), 11.1]

10. **Claims Data**. Provider shall cooperate with CalOptima's obligations under the QHP Contract to maintain historical Claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from the date that the QHP Contract is terminated with respect to Covered Services provided to Members during the term of the QHP Contract. These records shall include the data elements required to produce specific reports mutually agreed upon by Covered California and CalOptima and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable Regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductibles, out-of-pocket costs, and other cost-sharing for each Claim. [QHP Contract §§ 4.4.1(d)(xiv) and (xii), 11.2(c)]

11. **Financial Records**. Financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by Provider in connection with the QHP Contract shall be retained by Provider for at least ten (10) years from the date of the final Claims payment, unless a longer maintenance period is required by Laws or the QHP Contract. Provider shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to Provider. This shall include: (i) adequate data customarily maintained and reasonably necessary to properly document each of Provider's transactions with CalOptima during the period the QHP Contract remains in force; and (ii) records of Claims, including medical review and high dollar special audit Claims. [QHP Contract §§ 1.12, 4.4.1(d)(xiv), (xxii), 11.2(a), 11.2(b)]

12. **Books and Records Location**. Books and records shall be kept in a secure location at Provider's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by CalOptima, Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10)-year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), 11.3]

13. **Notice.** Provider shall promptly notify CalOptima in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Provider, personnel, or Subcontractors that is threatened or commenced by any governmental authority or other party that a reasonable person might believe could materially affect the ability of CalOptima to perform in accordance with the terms set forth in the QHP Contract. [QHP Contract §§ 4.4.1(d)(xxii), 11.6]

14. **Scope of Licensure**. All Covered Services must be provided by duly licensed, certified, or accredited providers consistent with the scope of their Licenses and in accordance with applicable Laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in this Contract and the QHP Contract. [QHP Contract § 4.4.1(a)]

15. **QHP Contract Requirements**. Provider agrees to be bound, and to bind each of its Subcontractors, by all provisions of the QHP Contract that are applicable to the Covered Services that Provider and its Subcontractors provide under the Contract [QHP Contract § 4.4.1(d)], including:

15.1. Coordination with Covered California and other programs and stakeholders.

15.2. Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and CalOptima's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].

15.3. Participating Provider directory requirements [QHP Contract § 4.4.4].

15.4. Symphony Provider directory requirements [QHP Contract § 4.4.5)].

15.5. Implementation of processes to enhance stability and minimize disruption to the provider network [QHP Contract § 4.3.3].

15.6. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].

15.7. Provider credentialing, including maintenance of licensure and insurance [QHP Contract § 3.4.2].

15.8. Customer service standards [QHP Contract § 4.6].

15.9. Utilization managements processes [QHP Contract § 5.3].

15.10. Maintenance of a corporate compliance program [QHP Contract § 1.2].

15.11. Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].

15.12. Appeals and grievances [QHP Contract § 4.6.2].

15.13. Member and marketing materials [QHP Contract § 3.2].

15.14. Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.12], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].

15.15. Nondiscrimination [QHP Contract § 1.10].

15.16. Conflict of interest and integrity [QHP Contract § 1.11].

15.17. Other Laws [QHP Contract § 1.13].

15.18. Advancing equity, quality, and value to the extent applicable to Participating Providers [QHP Contract Article 5], including disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 1, Advancing Equity, Quality, and Value, to the QHP Contract.

15.19. Performance measures, to the extent applicable to Participating Providers [QHP Contract Article 7].

15.20. Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.3 and Article 8].

15.21. Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].

15.22. Maintenance of books and records [QHP Contract Article 11].

16. **Cooperation**. Provider recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, CalOptima, Provider, and any other authorized

Subcontractors. Provider shall coordinate and cooperate with CalOptima and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. Provider shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of the California Healthcare Eligibility, Enrollment, and Retention System with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other Laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.6]

17. **Subcontractor Selection**. Provider shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any CalOptima approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable Laws, rules, regulatory requirements, and orders. Provider's obligations pursuant to this Contract and applicable Laws shall not be waived or released if Provider is permitted to subcontract or otherwise delegate services of this Contract. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]

18. **Independent Contractors**. Nothing in the QHP Contract or this Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Provider or CalOptima and Provider. The Parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]

19. **Provider Directory**. Provider shall provide information to CalOptima to allow CalOptima to comply with its provider directory obligations under the QHP Contract. Provider acknowledges that Covered California may use Provider's data for any noncommercial purposes. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

20. **Member Liability**. Provider shall comply with Laws governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if CalOptima fails to pay an amount owed by CalOptima to Provider. Provider shall inform every Member in a manner that allows the Member the opportunity to act upon Provider's proposal or recommendation regarding (i) the use of a non-Participating Provider or (ii) the referral of a Member to a non-Participating Provider for proposed non-Emergency Services. Provider shall disclose to a Member considering accessing non-Emergency Services from a Participating Provider if a non-Participating Provider will be used as part of the Participating Provider's plan of care. Provider is responsible for complying with the Provider Manual and may rely upon the provider directory of CalOptima in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]

21. **Credentialing**. If Provider is delegating activities relating to credentialing and re-credentialing, the process used by Provider must be reviewed and approved by CalOptima and as otherwise required by DMHC or any other applicable Regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]

22. **Utilization Management**. Provider shall cooperate and comply with and participate in the UM Program established by CalOptima in compliance with Laws, including HSC § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]

23. **Eligibility and Enrollment Determinations**. Provider shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to CalOptima in its efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2, Article 3]

24. **Grievances and Appeals**. Provider shall cooperate and comply with the internal review process established by CalOptima to resolve Member written or oral grievances and appeals, including those involving expressions of dissatisfaction regarding Provider. Provider shall comply with State and federal Laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2]

25. **Quality, Network Management, and Delivery System Standards**. Provider shall cooperate and comply with programs established by CalOptima consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to CalOptima to ensure CalOptima's compliance with its required reporting obligations pursuant to Attachment 1, Advancing Equity, Quality, and Value, of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]

26. **Customer Service Standards**. Provider shall comply with all applicable QHP Contract customer service standards that are applicable to Provider. [QHP Contract §§ 4.4.1(d)(viii), 4.6]

27. **Continuity of Care**. Provider agrees to comply with policies and procedures implemented by CalOptima to enhance stability and minimize disruption to CalOptima's provider networks. Provider shall provide CalOptima with the information necessary to comply with notice and other requirements in the cases of block transfers (HSC § 1373.65) and network disruptions (HSC §§ 1373.23 and 1366.1). In the event of a change related to network disruption, block transfers, or other similar circumstances, Provider shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under Laws, including those relating to continuity of care set forth at HSC § 1373.95 and as otherwise set forth in the QHP Contract. In the event of termination of the QHP Contract or decertification of one or more of CalOptima's QHPs, Provider shall cooperate fully with CalOptima and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(xx), 4.3.3, Article 8]

28. **Fraud, Waste, and Abuse Programs**. Provider shall maintain compliance and provide CalOptima with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance of its obligations and CalOptima's reporting obligations under the QHP Contract. [QHP Contract §§ 4.4.1(d)(x), 1.2, 1.15]

29. **Insurance**. Provider shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable Laws. [QHP Contract § 9.1.3]

30. **No Surprises Act**. Provider shall comply with the rules against surprise billing in the Consolidated Appropriations Act of 2021 (the "**No Surprises Act**"), including complying with applicable cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections. If Provider is responsible for processing Claims for Covered Services rendered by out-of-network providers, Provider shall process such Claims in accordance with the No Surprises Act. [HSC § 1371.9; 45 CFR §§ 149.410, 149.420, 149.430, 149.440]

31. **CalOptima Accountability.** Notwithstanding any relationship CalOptima may have with Provider, as Delegated Entity, and any Downstream Entity, CalOptima maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR § 156.340(a). [45 CFR § 156.340(a)]

32. **Delegated Entity and Downstream Entity Compliance.** If any of CalOptima's issuer activities and obligations, in accordance with 45 CFR § 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to the following provisions and Provider further agrees that it will require Downstream Entities to comply with the same standards. [45 CFR § 156.340(b)]

    32.1. **Standards for Downstream and Delegated Entities.** The Contract, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. [45 CFR § 156.340(b)(1)]

32.2. **Revocation of Delegated Activities.** In the event the HHS or CalOptima determines, in its sole discretion, that Provider or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR § 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or CalOptima, as applicable. [45 CFR § 156.340(b)(2)]

32.3. **Compliance with Laws.** Provider will perform such activities and obligations in compliance with all applicable Laws and regulations relating to the standards specified in 45 CFR §156.340(a). [45 CFR § 156.340(b)(3)]

32.4. **Right to Audit.** Provider and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the OIG, or their designees, to evaluate through audit, inspection, or other means, Provider's or the Downstream Entity's books, contracts, computers, or other electronic systems, including Medical Records and documentation, relating to CalOptima's obligations in accordance with the standards enumerated at 45 CFR § 156.340(a), as applicable, until ten (10) years from the final date of the Contract period. [45 CFR § 156.340(b)(4)-(5)]

33. **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits CalOptima from entering into a contract with Provider, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict CalOptima from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or Members, or individuals eligible to become participants, beneficiaries, or Members of the plan or coverage; (ii) electronically accessing de-identified Claims and Encounter Data for each participant, beneficiary, or Member; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Contract, Provider agrees that CalOptima is in compliance with this provision with respect to this Contract and nothing in this Contract will prohibit CalOptima from complying with this provision.

Knox-Keene Act Addendum

This Knox-Keene Act Addendum shall only apply to the Program(s) governed by the Knox-Keene Act and regulated by the DMHC. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, or PACE Programs.

1. **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of Health & Safety Code ("**HSC**") 1367.03 and 28 CCR § 1300.67.2.2 and in a manner that provides continuity of care, including the availability of PCPs who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or Provider to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and State Laws. Provider shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Provider has any role in rendering Emergency Services, Provider will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Provider shall provide reporting required by CalOptima and DMHC necessary to ensure compliance with DMHC accessibility and network adequacy standards. Provider will comply with CalOptima's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments.

[HSC §§ 1367, 1367.03, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]

2. **Licensure and Certification**. As applicable, Provider and its employed and contracted personnel shall be licensed and certified by their respective board or agency, where licensure or certification is required by law to provide services under the Contract. As applicable, any equipment used by Provider and/or its employed and contracted personnel under the Contract required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. [H&S Code § 1367(b)-(c)]

3. **Coordination of Member Care.** Provider is responsible for coordinating the provision of health care services to a Member if Provider is acting as the Member's PCP. Provider shall maintain Member Medical Records in a readily available manner that permits sharing with CalOptima of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]

4. **Provider Directory Information.** Provider shall inform CalOptima within five (5) Business Days of material changes that would affect Provider's or its Contracted Providers' listing in CalOptima's provider directory, so that CalOptima can comply with HSC § 1367.27. Material changes include:

   4.1. The addition or deletion of a Contracted Provider from Provider's group of providers.

   4.2. A change in Provider's or a Contracted Provider's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.

   4.3. Whether Provider or its Contracted Providers are or are not accepting new patients.

   If Provider or one of its Contracted Providers is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Provider shall direct the Member or potential Member to CalOptima for additional assistance in finding a provider and to DMHC to report any inaccuracy with CalOptima's directories.

   Provider shall provide to CalOptima any information necessary for CalOptima to comply with State Laws. If Provider does not comply with this provision or demonstrates a pattern of repeated failure, CalOptima may terminate the Contract. [HSC § 1367.27]

5. **Notices to Members of Termination or Block Transfer.** Provider shall cooperate and assist CalOptima in fulfilling CalOptima's obligations under 28 CCR § 1300.67.1.3 regarding block transfer filings with the DMHC. Any written communications to Members that concern a termination of this Contract or block transfer shall comply with the notification requirements in HSC § 1373.65(f). CalOptima shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]

6. **Continuation of Care after Termination for Certain Conditions.** If the Contract is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Provider will, at the request of the Member and CalOptima, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Reimbursement for such services will be at the applicable rates listed in Attachment B, *Compensation*. Upon termination of the Contract, CalOptima is liable for the Covered Services rendered by Provider (other than any permissible co-payments, co-insurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Provider's care at the time of termination of the Contract until the Covered Services the Provider is rendering to the Member are completed or until CalOptima makes reasonable and medically

appropriate provisions for the assumption of such services by another Participating Provider. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]

7. **Quality Assurance Program.** CalOptima will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Provider will assist CalOptima in maintaining CalOptima's quality assurance program, as applicable, and consistent with CalOptima's quality assurance program policies and procedures. To the extent that any of CalOptima's quality assurance functions are delegated to Provider, Provider shall promptly deliver to CalOptima all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions and so that CalOptima may comply with Laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2(d), 1300.70]

8. **No Inducement to Deny Covered Services.** Provider acknowledges and agrees that this Contract does ***not*** (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Provider to induce Provider to provide care to Members in a manner inconsistent with coverage requirements. Provider shall ensure that its contracts with individual providers similarly comply with this Section 8. [HSC §§ 1348.6, 1367.62(a)(3)]

9. **Appeals and Grievances of Members.** CalOptima will be responsible for resolving Member appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. CalOptima's process to resolve provider grievances are set forth in the Contract and CalOptima Policies. Provider will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Provider shall assist and cooperate with CalOptima in responding to Member grievances and requests for independent medical reviews consistent with CalOptima Policies, including the Provider Manual. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a) and (b)]

10. **Language Assistance Program Standards.** Provider shall comply with the language assistance standards promulgated by the DMHC and with CalOptima's language assistance program and shall cooperate with CalOptima in providing any information necessary to assess compliance. [HSC § 1367.04(f); 28 CCR § 1300.67.04]

11. **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Provider will not invoice or balance bill any Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima or its capitated provider for any Covered Service. In addition, in the event CalOptima or its capitated provider fails to pay for Covered Services, Members will not be liable to Provider for any sums owed by CalOptima or its capitated provider. Provider shall not maintain any action at law against a Member to collect sums owed by CalOptima or its capitated provider. [HSC §§ 1379(a)-(c), 1371.9; 28 CCR § 1300.71(g)(4)]

12. **No Surcharges.** Neither Provider nor Provider's agents, trustees, or assignees shall impose or collect a surcharge from a Member for services provided to the Member pursuant to the Contract, nor shall Provider nor Provider's agents, trustees, or assignees maintain any action at law against a Member to collect sums owed by CalOptima to Provider for services provided to the Member pursuant to the Contract. In its agreements with individual providers, Provider shall (i) prohibit individual providers from imposing or collecting a surcharge from a Member for services provided to the Member pursuant to the agreement with Provider and (ii) prohibit the individual provider from maintaining any action at law against a Member to collect sums owed by Provider to the individual provider for services provided to the Member pursuant to the agreement with Provider. Upon notice of any such action or upon notice that Provider or any individual provider has imposed surcharges for Covered Services, CalOptima will take appropriate action. As used in this addendum, the term "**surcharges**" means an additional fee that is charged to a Member for a Covered Service, but that is not approved by the Director of the DMHC ("**Director**"). [HSC § 1379(c); 28 CCR § 1300.67.8(d)]

13. **Reporting or Surcharges and Cost-Sharing.** Provider will report to CalOptima in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Provider. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]

14. **Third Party Recoveries.** Provider shall cooperate with CalOptima in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Provider from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other Laws.

15. **Claims for Secondary Payment.** CalOptima or its capitated provider will pay Claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. Notwithstanding any other provision in this Contract, if CalOptima or CalOptima's capitated provider is not the primary payer under coordination of benefits, Provider may submit Claims to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer. Except as otherwise provided by Laws or provided by Government Program Requirements, any Claims that are not submitted by Provider to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment thereof. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]

16. **Good Cause for Late Filing.** If CalOptima or CalOptima's capitated provider denies a Claim because it was filed beyond the Claim filing deadline, CalOptima will, upon Provider's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

17. **Authorization of CalOptima's Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment CalOptima makes in future payments to Provider, CalOptima shall furnish Provider with a separate written notice of the Overpayment that clearly identifies the overpaid amount, Claim, Member's name, Date(s) of Service, and explains the basis for CalOptima's request for reimbursement of the Overpayment, including any interest and penalties on the Claim. If Provider intends to contest CalOptima's notice, Provider must send written notice of Provider's intent to contest within thirty (30) Business Days of Provider's receipt of CalOptima's notice. If CalOptima does not receive a notice of intent to contest notice of the Overpayment or the requested reimbursement from Provider within the above timeframes, Provider authorizes CalOptima to offset or recoup the requested reimbursement amount from CalOptima's payments to Provider for current or future Claim submissions. [28 CCR § 1300.71(d)]

18. **Provider Dispute Resolution.** CalOptima shall establish and maintain a provider dispute resolution process to process and resolve any Provider disputes, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Provider may obtain specific information regarding CalOptima's provider dispute resolution process in CalOptima's policies. Provider has a right to access CalOptima's provider dispute resolution process. CalOptima will inform Provider of any changes to CalOptima's provider dispute resolution procedures. Provider will receive the rights listed in HSC § 1375.7, as amended, if CalOptima makes any changes to the provider dispute resolution process. Provider may utilize CalOptima's provider dispute resolution process or obtain information about the process by writing to Provider Dispute Resolution Claims at the appropriate address outlined in the Provider Manual or calling: (714) 246-8600. CalOptima's provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1 *et seq.* See the Provider Manual for current information regarding CalOptima's provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h)(1) and (2); 28 CCR §§ 1300.71.38, 1300.71(e)]

19. **Member Confidentiality.** Provider will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the Confidentiality of Medical Information Act ("**CMIA**"), including California Civil Code §§ 56.10, 56.104, and 56.107. Provider shall prohibit individual providers from disclosing medical information regarding a Member unless such disclosure complies with the requirements of the CMIA. [HSC §§ 1348.5, 1364.5; 28 CCR §§ 1300.51(d) K.2, 1300.67.8(a)]

20. **Maintenance and Access to Records.**

20.1. Provider will prepare and maintain on a current and accurate basis all records, books, and papers related to this Contract ("**Records**") possessed in any medium. Such Records shall be made available for inspection, including through electronic means, and copying by CalOptima and/or the DMHC, as may be necessary for CalOptima's compliance with the provisions of the Knox-Keene Act and the rules.

20.2. To the extent feasible, all Records shall be located in the State of California and shall not be removed without DMHC's prior consent. If Records are located outside California, Provider shall make such Records available in California or furnish true and accurate copies of such Records.

20.3. If CalOptima and/or DMHC requests to inspect Records, Provider shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

20.4. To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format. Records must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

20.5. Provider shall cooperate with CalOptima with respect to any DMHC examination of the fiscal and administrative affairs of CalOptima or CalOptima's subcontractors.

20.6. Provider shall maintain on a current and accurate basis and ensure ready availability of Medical Records. Upon CalOptima's request, Provider shall make available, at reasonable times, Provider's Records relating to the services provided to Members, to the cost thereof, to payments received by Provider from Members (or from others on their behalf).

20.7. The obligation under this Section 20 shall survive termination of the Contract for any reason.

[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

21. **Amendments.** The Provider Manual may be unilaterally amended or modified by CalOptima to maintain consistency or compliance with any Laws, policies, directives, government program requirements, or requirements of an Accreditation Organization upon forty-five (45) Business Days' notice to Provider unless a shorter timeframe is necessary for compliance. CalOptima may otherwise materially amend the Provider Manual only after forty-five (45) Business Days' prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Provider. If CalOptima receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Provider has the right to terminate this Contract prior to the effective date of the amendment or modification.

[HSC § 1375.7; 28 CCR § 1300.71(m)]

22. **Compliance with Laws.** CalOptima is subject to Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Contract shall bind the Parties whether or not expressly set forth in this Contract.

23. **Quality and Utilization.** CalOptima will disclose to Provider CalOptima's quality improvement or UM programs and procedures at least fifteen (15) Business Days prior to Provider executing this Contract. A change to the quality improvement or UM programs or procedures shall be made pursuant to Section 21. Notwithstanding the foregoing, CalOptima may make a change to the quality improvement or UM programs or procedures at any time if the change is necessary to comply with Laws or any accreditation requirements of a private sector Accreditation Organization. [HSC § 1375.7(b)(3)]

24. **Data Usage.** The provisions of this section will apply only to the extent that Provider, now or in the future, acts as a "**Service Provider**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code §§ 1798.100 *et seq.*, 1798.140(v), and the regulations promulgated thereunder). Provider warrants and represents that all Personal Information (as defined below) shall not be: (i) retained, used, or disclosed by Provider for any purpose other than for the specific purpose of performing the services specified in the Contract; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Provider shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Contract or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140(t)(1). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140(o).

25. **Health Care Providers' Bill of Rights**. Provider is entitled to all protections afforded to Provider under the Health Care Providers' Bill of Rights. [HSC § 1375.7]

26. **Telehealth Services**. If Provider uses telehealth for rendering Covered Services, Provider shall obtain and document Member consent prior to providing telehealth services, as required under Business and Professions Code § 2290.5. As required by HSC § 1374.14, CalOptima shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately delivered through telehealth services on the same basis and to the same extent that CalOptima is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or behavioral health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. If CalOptima delegates responsibilities under HSC § 1374.141 to a contracted entity, the delegated entity shall comply with this section and HSC § 1374.141, as applicable, including obtaining Member consent for use of telehealth services and complying with the records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]

27. **Liabilities**. CalOptima and Provider are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Contract is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part CalOptima or Provider based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]

28. **Reporting.** Provider agrees to submit all information or reports required under this Contract or requested by CalOptima or DMHC to comply with Laws in a form acceptable to CalOptima or DMHC, including providing necessary information and reports under HSC § 1367.0061.

29. **Mental Health Parity Requirements**. As applicable, Provider shall comply with all Laws and

CalOptima Policies on the provision of Medically Necessary Treatment of Mental Health and Substance Use Disorder, as defined by HSC § 1374.72(a) ("**MH/SUD Services**"). As applicable, Provider shall adopt and use CalOptima Policies when providing MH/SUD Services or, if Provider establishes its own policies, Provider shall obtain CalOptima's prior written approval and shall ensure Provider's policies comply with applicable requirements of HSC §§ 1374.72 and 1374.721, and 28 CCR § 1300.74.72 and 1300.74.721.

ATTACHMENT E
LOBBYING CERTIFICATION FORMS

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

@@Provider Name@@	{{Name_es_:signer1: }}
Name of Contractor	Printed Name of Person Signing for Contractor
	{{_es_:signer1:signature}}
Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }}	{{_es_:signer1:title }}
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

@@Custom Field{Lobby Check Box}@@

CERTIFICATION REGARDING LOBBYING

Approved by OMB

0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: {{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	2. Status of Federal Action: {{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	3. Report Type: initial {{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity: {{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: {{RepEntNm_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDist _es_signer1 }}
6. Federal Department/Agency: {{FedDept_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA _es_signer1 }}
8. Federal Action Number, if known: {{FedDept_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s))	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature Value {{Value_es_:signer1 }}	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}}

Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

{{lobby_es_:checkbox:signer1}}

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks “Subawardee,” then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., “RFP-DE-90401.”

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503

HOSPITAL SEVICES CONTRACT

between

ORANGE COUNTY HEALTH AUTHORITY DBA CAL OPTIMA HEALTH

and

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HOSPITAL SERVICES CONTRACT

This Hospital Services Contract ("**Contract**") is effective [insert effective date] ("**Effective Date**") by and between Orange County Health Authority, a public agency, dba CalOptima Health, ("**CalOptima**"), and [**HOSPITAL NAME**] ("**Hospital**"), a California corporation. CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System formed pursuant to Welfare and Institutions Code § 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008.

B. CalOptima contracts with the State of California, acting through the Department of Health Care Services ("**DHCS**"), the U.S. Department of Health and Human Services ("**HHS**"), acting through the Centers for Medicare & Medicaid Services ("**CMS**"), and California Department of Aging ("**CDA**"), and Covered California to arrange and pay for health care services rendered to beneficiaries who are enrolled in CalOptima's OneCare (a dual eligible special needs Medicare Advantage plan), Medi-Cal, MSSP, Covered California and PACE programs ("**Programs**").

C. Hospital provides the items and services described in this Contract and has all certifications, licenses, and permits necessary to furnish such items and services.

D. CalOptima desires to engage Hospital to furnish, and Hospital desires to furnish, certain items and services to Members as described herein. CalOptima and Hospital desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

Capitalized words or phrases not otherwise defined in this Contract shall have the meanings set forth below:

1.1. "**Accreditation Organization**" means any organization engaged in accrediting, certifying and/or approving CalOptima, Hospital, and/or their respective programs, centers, or services, including the National Committee for Quality Assurance ("**NCQA**") and The Joint Commission.

1.2. "**Advance Directive**" means a written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make their health care wishes known.

1.3. "**Agent**" means a person who has the authority to obligate or act on behalf of Hospital, CalOptima, or a Regulator.

1.4. "**Aid Code**" means the two-character code, defined by the State, that identifies the aid category under which a Member is eligible to receive Covered Services.

1.5. "**APLs**" and "**Policy Letters**" are means by which DHCS and/or DMHC convey information or interpretation of changes in policy or procedure at the federal or State levels. APLs (also known as

all plan letters) and Policy Letters provide instruction about changes in Laws and how services are delivered to Members.

1.6. "**Appeals**" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

1.7. "**Authorization**", "**Authorize**", or "**Authorized**" means the written, telephonic, or deemed approval of CalOptima or its delegate for the provision or referral of Covered Services, other than Emergency Services, in accordance with CalOptima Policies, Laws, and this Contract. Any Authorization remains subject to CalOptima's UM determinations.

1.8. "**Business Day**" means Monday through Friday, except for legal holidays under State law, which are identified on the California Department of Human Resources' State Holidays website.

1.9. "**California Children's Services ('CCS')**" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10. "**CalOptima Policies**" means the policies and procedures relevant to this Contract, including those set forth in CalOptima's Provider Manual, provider newsletters, or other written communications to providers, and as amended from time to time at the sole discretion of CalOptima. CalOptima Policies include network management, quality management and improvement, utilization review, credentialing, peer review, Claims billing and reimbursement, member rights and responsibilities, and grievances and appeals.

1.11. "**CCR**" means the California Code of Regulations.

1.12. "**CCS Eligible Condition(s)**" means a physically handicapping condition, as defined in 22 CCR §§ 41515.2-41518.9.

1.13. "**CCS-Paneled Provider(s)**" means any of the following providers when used to treat Members for CCS Eligible Conditions:

1.13.1 A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with § 123800 of Chapter 3 of Part 2 of Division 106).

1.13.2 A licensed acute care hospital approved by the CCS Program.

1.13.3 A special care center approved by the CCS Program.

1.14. "**CCS Program**" means the State public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.15. "**CFR**" means the Code of Federal Regulations.

1.16. "**Claim**" means a request for payment submitted by Hospital for services provided to a Member.

1.17. "**Clean Claim**" means a "Complete Claim" under Laws, including (as applicable) 28 CCR § 1300.71(a)(2), that also complies with the terms of this Contract and CalOptima Policies.

1.18. "**COB**" refers to the coordination of benefits determinations of the order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

1.19. "**COD**" means a direct program CalOptima administers for Members not enrolled in a Health Network. COD consists of two components:

1.19.1 COD Members who are assigned to a Community Network in accordance with CalOptima Policies.

1.19.2 "**COD-Administrative**" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal SOC, or are eligible for both Medicare and Medi-Cal.

1.20. "**Community Network**" means CalOptima's direct health network that serves Members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to primary care providers ("**PCPs**") as their medical home, and their care is coordinated through the PCP.

1.21. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of CalOptima's Board of Directors, employees, contractors, and providers comply with Laws and ethical standards. The Compliance Program includes CalOptima's fraud, waste, and abuse ("**FWA**") plan.

1.22. "**Contracted Provider**" means a Provider that is contracted with Hospital to provide Covered Services to Members. All Contracted Providers are considered Subcontractors.

1.23. "**County**" means the County of Orange, State of California.

1.24. "**Covered Services**" means the Medically Necessary health care items, drugs, and services that a Member is entitled to receive under the Member's Program and are identified in Attachment A. Covered Services must generally be Authorized in accordance with CalOptima's Policies, including its utilization management program, except for Emergency Services.

1.25. "**DHCS Contract**" means the written agreement between CalOptima and DHCS pursuant to which CalOptima arranges and pays for the provision of Covered Services to certain Medi-Cal beneficiaries in the County.

1.26. "**Emergency Medical Condition**" means, unless otherwise provided in an attachment to this Contract with regard to a specific Program, a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:

1.26.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

1.26.2 Serious impairment to bodily functions;

1.26.3 Serious dysfunction of any bodily organ or part; or

1.26.4 Death.

1.27. "**Emergency Services**" has the same meaning, unless otherwise provided in an attachment to this Contract with regard to a specific Program, as defined in 42 CFR §§ 422.113(b) and 438.114(a).

1.28. "**Encounter Data**" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. Encounter Data records shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by Regulators.

1.29. "**Family Planning**" means Covered Services that are provided to Members of childbearing age to enable them to determine the number and spacing of their children and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes:

1.29.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.29.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.29.3 Patient visits for the purpose of Family Planning;

1.29.4 Family Planning counseling services provided during a regular patient visit;

1.29.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.29.6 Tubal ligations;

1.29.7 Vasectomies;

1.29.8 Contraceptive drugs or devices; and

1.29.9 Treatment for complications resulting from previous Family Planning procedures.

Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.30. "**Government Contract(s)**" means the written contract(s) between CalOptima and the federal and/or State government, including the DHCS Contract, pursuant to which CalOptima administers and pays for Covered Services under a Program.

1.31. "**Health Network**" means a physician group under a shared risk contract, physician-hospital consortium, or health care service plan licensed under the Knox-Keene Act that contracts with CalOptima on a capitated basis to provide Covered Services to non-COD Members.

1.32. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including Regulators' operational guidance and other instructions related to the coverage, payment, and/or administration of Programs. Any state or federal statute, regulation, rule, or executive or agency order that only applies to a certain Program(s) shall only be considered part of Laws with respect to the Program(s) to which the state or federal statute,

regulation, rule, or executive or agency order applies. Laws do not include any State statute, regulation, rule, or executive or agency order preempted by federal law.

1.33. "**Licenses**" means all licenses, certifications, accreditations, approvals, and permits that Hospital is required to have in order to participate in the Programs and furnish the items and/or services under this Contract.

1.34. "**LTC Facility**" means a long-term care facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.35. "**Medi-Cal**" is the Medicaid program for the State (*i.e.,* the program authorized by Title XIX of the federal Social Security Act ("**SSA**") and the regulations promulgated thereunder).

1.36. "**Medically Necessary**" or "**Medical Necessity**" means reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Welfare & Institutions ("**W&I**") Code § 14059.5(a) and 22 § CCR § 51303(a). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, Medical Necessity includes the standards in 42 USC § 1396d(r), as required by WI Code §§ 14059.5(b) and 14132(v).

1.37. "**Medical Record(s)**" means any record kept or required to be kept by any Provider that document all of the medical services received by the Member, including inpatient, outpatient, emergency care, and referral requests and Authorizations, as required by Laws and CalOptima Policies.

1.38. "**Medicare**" means the federal health insurance program defined in Title XVIII of the SSA and the regulations promulgated thereunder.

1.39. "**Member" or "Members**" means any person who is eligible to receive Covered Services and is enrolled in a Program.

1.40. "**Minimum Standards**" means the minimum participation criteria established by CalOptima that Providers must satisfy to receive reimbursement from CalOptima for items and/or services furnished to Members, as further described in CalOptima Policies.

1.41. "**MOU**" means (i) an agreement between CalOptima and another government agency that delineates responsibilities for coordinating care to Members, and (ii) a contract between CalOptima and the County that incorporates such agreements, including the Coordination and Provision of Public Health Care Services Contract.

1.42. "**Overpayment**" means a payment Hospital receives that, after applicable reconciliation, Hospital is not entitled to receive or retain pursuant to Laws, Government Contracts, and/or this Contract.

1.43. "**Participating Provider**" means an institutional, professional, or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.44. "**Participation Status**" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in any federal and/or State health care programs and/or felony conviction, as specified in the Compliance Program and CalOptima Policies.

1.45. "**Preclusion List"** means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.46. "**Privacy Requirements**" means the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), California W&I Code § 14100.2, as amended, and the implementing regulations of those laws, including CCR § 51009 and 42 CFR § 431.300 *et seq.*

1.47. "**Program(s)**" means any of the following programs administered by CalOptima: the Medi-Cal, OneCare, the Multipurpose Senior Services Program ("**MSSP**"), Covered California, or the Program of All-Inclusive Care for the Elderly ("**PACE**"). Hospital participates in the specific Program(s) identified in Attachment A.

1.48. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, or other person or institution that furnishes health care items or services.

1.49. "**Regulators**" means those government agencies that regulate and oversee CalOptima, including the HHS Inspector General, CMS, DHCS, the Department of Justice ("**DOJ**"), the DOJ Bureau of Medi-Cal Fraud, the California Department of Managed Health Care ("**DMHC**"), the Comptroller General, Covered California, and any other government agencies that have authority to set standards and oversee the performance of the Parties.

1.50. "**SOC**" means the share of cost the Member owes as part of receiving Covered Services, including co-payments, and deductibles.

1.51. "**Specialist**" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.52. "**Stabilize(d)**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

1.53. "**State**" means the State of California.

1.54. "**Subcontract**" means a contract between Hospital (or its Subcontractor) and a Subcontractor that agrees to provider services related to Hospital's obligations under this Contract.

1.55. "**Subcontractor**" means any Provider, entity, or person that entered into Subcontract with Hospital (or another Subcontractor) related to fulfilling any of Hospital's obligations under this Contract, including Contracted Providers.

1.56. "**TRI**" means the set of provider targeted rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) and implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment

previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

1.57. "**Urgent Care Services**" means Covered Services that are not Emergency Services but are required to prevent serious deterioration of a Member's health following the onset of an unforeseen condition or injury for which treatment cannot be delayed, as specifically defined by the rules and regulations governing the applicable Program.

1.58. "**UM**" means the utilization management or utilization review of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

1.59. "**WCM Program**" means CalOptima's Whole Child Model program whereby CCS is a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
HOSPITAL OBLIGATIONS

2.1. **Covered Services**.

2.1.1. Hospital shall furnish the Covered Services that are Authorized by CalOptima (except for Emergency Services, which do not require Authorization) and listed in Attachment A to eligible Members. Hospital shall furnish such items and services in a manner satisfactory to CalOptima and its Regulators in accordance with Laws, Program requirements, Government Contracts, and CalOptima Policies.

2.1.2. Hospital shall make Covered Services available and accessible to Members promptly and in a manner which ensures continuity of care and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

2.1.3. Throughout the Term, Hospital shall maintain the quality of its services and personnel in accordance with the requirements of this Contract, Laws, Government Contracts, Program requirements, and CalOptima Policies.

2.2. **Licensure and Qualifications**.

2.2.1 Hospital shall be, and remain during the Term, duly licensed by the State as a general acute care hospital. Hospital represents and warrants that it is currently in good standing, and at all times during the Term shall maintain good standing, and has all Licenses required under Laws to provide Covered Services under this Contract, including (i) certification under and enrollment in Medicaid and Medicare; (ii) accreditation by The Joint Commission and any other Accreditation Organizations, as necessary to provide Covered Services; (iii) all provider and/or supplier numbers necessary to perform its obligations under this Contract, including National Provider Identifiers ("**NPIs**"); and (iv) being in good standing with State licensing boards applicable to its business, DHCS, CMS, and the HHS Office of Inspector General ("**OIG**"), as applicable.

2.2.2 Hospital shall ensure that every provider providing Covered Services and employed or engaged by Hospital or Subcontractors shall at all times during the Term retain all valid

licenses, certifications, and qualifications, without restriction, and meet Minimum Standards as necessary to provide or arrange for the provision of Covered Services to Members and bill for those Covered Services.

2.2.3 Hospital or its delegate shall additionally verify the qualifications of all employees and Subcontractors providing services under this Contract consistent with the services to be provided. For employees and Subcontractors who have face-to-face contact with Members, Hospital or its delegate shall also conduct background investigations, including county, state, and federal criminal history and abuse registry screening. Hospital and its delegates shall comply with all Laws in conducting background investigations and shall exclude unqualified employees and Subcontractors from providing services under this Contract.

2.2.4 Hospital shall notify CalOptima in writing and provide all correspondence with and notices from any government agencies or Accreditation Organizations regarding (i) investigations into Hospital or its Subcontractors; (ii) citations and/or disapprovals of Hospital for a failure to meet any material Laws or Accreditation Organization standard; or (iii) the issuance of criminal, civil, and/or administrative sanctions (threatened or imposed) related to Hospital's or a Subcontractor's licensure, fraud and abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.3. **Credentialing and Recredentialing**. Hospital shall ensure all Subcontractors comply with CalOptima's credentialing and recredentialing procedures, as applicable and required by CalOptima Policies, Government Contracts, and Laws. Only providers who CalOptima has determined meet applicable CalOptima credentialing criteria may be considered Contracted Providers.

2.4. **Professional Standards**. All Covered Services under this Contract shall be provided or arranged by duly licensed, certified, or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract, Government Contracts, and CalOptima Policies; (ii) within professionally recognized standards of practice at the time of treatment; and (iii) in accordance with the Laws and CalOptima's UM and quality management ("**QM**") programs.

2.5. **Eligibility**. Hospital shall verify a Member's eligibility for the applicable Program benefits upon receiving a request for Covered Services and at the beginning of each calendar month thereafter during the continued provision of such Covered Services. For Members SOC obligations, Hospital shall collect SOC in accordance with CalOptima Policies and Laws.

2.6. **Medi-Cal Member Retroactive Eligibility**. For Covered Services provided to Members whose eligibility in Medi-Cal has been determined retroactively, Hospital agrees to the following:

2.6.1 To verify eligibility of Members through the State's Beneficiary Eligibility Verification system and to report such eligible Members to CalOptima within forty-eight (48) hours of Hospital becoming aware of Member's eligibility.

2.6.2 Except for Emergency Services that CalOptima is not financially responsible for, any services rendered by Hospital if Hospital fails to notify CalOptima within forty-eight (48) hours of becoming aware of a Medi-Cal Member's eligibility.

2.6.3 The admission and length of stay of the Member shall be subject to retrospective review for Medical Necessity.

2.6.4 To submit complete Medical Records with all submitted Claims.

2.7. **Compliance with Laws and Policies**. Hospital shall comply with all Laws in effect during the Term that in any manner affect Hospital's performance under this Contract. This Contract shall be governed by and construed in accordance with Laws and Government Contracts. Hospital shall also comply with all applicable CalOptima Policies.

2.8. **Emergency Services**. Hospital shall comply with all Laws governing the provision and payment of Emergency Services, as well as the applicable requirements of the Government Contracts.

2.8.1 Hospital shall furnish Emergency Services on a twenty-four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Hospital for Emergency Services without prior Authorization and in accordance with CalOptima Policies. CalOptima may only deny payment if CalOptima reasonably determines that Emergency Services were never performed.

2.8.2 CalOptima shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition. Further, CalOptima shall not deny payment for treatment obtained when CalOptima instructs a Member to seek Emergency Services.

2.8.3 If there is a disagreement between CalOptima and the treating emergency physician regarding the Medically Necessary of Covered Services in an emergency, the judgment of the attending physician(s) caring for the Member at the treating facility shall prevail. CalOptima may (i) send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment, or (ii) arrange to have a Participating Provider agree to accept the transfer of the Member after the Member has Stabilized. The attending physician actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge, and that determination is binding on CalOptima.

2.9. **Notification of Emergency Services**. Hospital shall notify CalOptima or the applicable Health Network within twenty-four (24) hours of a Member's initial presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first ("**Initial Encounter**"). If the Initial Encounter is on a holiday or weekend, Hospital shall notify CalOptima or the applicable Health Network the following Business Day.

2.10. **Transfer of Care**. Upon request by a Member, Hospital shall assist in the orderly transfer of the Member's medical care to another Provider. In doing so, Hospital shall make available to the new Provider copies of the Medical Records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of the Member. In no circumstance shall CalOptima or a Member be billed for this service.

2.11. **UM Program**. Hospital shall comply with CalOptima's UM Program, including the following:

2.11.1 Hospital shall comply with all concurrent and retrospective review and Authorization requirements set forth in CalOptima Policies. Prior Authorization is not required for Emergency Services.

2.11.2 Hospital shall allow CalOptima staff to initiate visits with Hospital staff immediately upon admission of any Member to evaluate the appropriateness of the admission and continued

stay, and Hospital shall comply with the evaluations and processes necessary for CalOptima to determine the Medical Necessity of items and services.

2.11.3 CalOptima's UM staff shall have access to timely information and documentation in order to enable CalOptima to review admissions in order to certify the number of inpatient days Authorized under the UM Program. Emergency Services provided within twenty-four (24) hours of an inpatient admission will be included in the inpatient per diems and/or case rates.

2.11.4 Except for Emergency Services, Hospital shall admit Members to Hospital only upon prior Authorization, including presentation to Hospital of the proper referral form or Authorization from CalOptima or a Health Network certifying the Covered Services and the number of Authorized inpatient days; provided, however, Hospital may admit a Member if it verifies, prior to admission, that CalOptima approved the admission in accordance with CalOptima Policies. Hospital shall provide non-Emergency Services to Members during the Term only upon CalOptima's prior Authorization, unless prior Authorization is not required for a particular item or service under the applicable Program. If Hospital does not request Authorization and Hospital does not receive Authorization prior to the provision of non-Emergency Services (including admission), CalOptima shall not pay Hospital for such non-Emergency Services. Hospital shall obtain a tracking number from CalOptima at the time of admission, which Hospital shall indicate on all UB-92 Forms submitted to CalOptima for Claims payment.

2.11.5 Hospital shall notify CalOptima within twenty-four (24) hours or the next Business Day from time of the admission or time Member identity is known or would have been known with the exercise of reasonable diligence. Hospital also agrees to request Authorization for all admissions to LTC Facilities. Furthermore, Hospital agrees to cooperate with CalOptima in discharge planning and transferring Members to Participating Providers, as is appropriate for all levels of care required by the Member and in accordance with CalOptima Policies. Hospital's failure to obtain pre-Authorizations and/or provide timely concurrent reviews may result in a reduction or denial in payment, in accordance with CalOptima Policies.

2.11.6 Hospital shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct concurrent reviews of the Medical Records of Members, including on site. CalOptima staff shall notify Hospital prior to conducting any on-site reviews, shall wear appropriate identification, and shall schedule times reasonable for Hospital.

2.12. **QM Program**. Hospital shall comply with CalOptima's QM Program and shall participate and cooperate in QM Program activities as required by CalOptima. Such activities may include (i) providing requested data; (ii) participating in assessment and performance audits and projects (including those required by Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members; and (iii) participating in QM Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for Members. Hospital shall cooperate with CalOptima and Regulators regarding any complaint, appeal or other review of Covered Services, including Medical Necessity, and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or Regulators, as applicable and as required under the applicable Program.

2.13. **Hospital Providers**. Upon CalOptima's request, Hospital shall provide CalOptima with a list of Hospital's medical staff members and any other information requested for the administration of

CalOptima's QM Program, unless such information is protected under California Evidence Code Section 1157 or other privilege statute. If a member of Hospital's medical staff is debarred from participation in a state or federal health care program and/or has his/her license to practice medicine suspended or revoked, Hospital shall recommend that the Hospital medical staff immediately prevent the physician from providing any services to Members. Hospital shall immediately notify CalOptima of any Provider who has been debarred from participating in a state or federal health care program or whose license to practice medicine has been suspended or revoked.

2.14. **Hospital Quality Improvement Program**. Hospital shall establish, maintain, and operate a quality improvement program, which shall include an annual quality improvement work plan and an annual performance evaluation of such work plan that is consistent with current industry standards, including those set forth by Quality Improvement System for Managed Care (QISMC), NCQA, Leapfrog, and/or The Joint Commission.

2.15. **QM Program Performance Data**. Hospital shall also allow CalOptima to use CalOptima and Hospital performance data for quality and reporting purposes, including quality improvement activities, public reporting to consumers, and performance data reporting to Regulators, as required Laws, Government Contracts, Laws, Programs, and CalOptima Policies.

2.16. **Changes in Capacity**. Hospital shall provide at least ninety (90) days' prior written notice to CalOptima of any significant changes in the capacity of Hospital or its Contracted Providers to furnish Covered Services to Members. Hospital shall use reasonable efforts to eliminate or remedy any condition that results in a significant adverse change in capacity, including (i) Hospital's inability to properly serve Members due to a lack of beds or other services; or (ii) closure of any facility or service unit used by Hospital or its Contracted Providers.

2.17. **Marketing Requirements**. Hospital shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.18. **Hospital Information**. CalOptima may list the name, address, and telephone number of Hospital and a description of Hospital's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Hospital and CalOptima agree that the use of the other Party's trademarks or logos in any form is prohibited without prior written approval of that Party.

2.19. **Health Networks**. Hospital acknowledges and agrees that CalOptima has delegated financial responsibility to Health Networks for certain Covered Services rendered to Members enrolled in Health Networks. Hospital agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks and to contract with a Health Network under the same terms as this Contract, at the request of a Health Network. Regardless of whether Hospital is contracted with a Health Network, Hospital also agrees to look solely to the applicable Health Network for payment for Covered Services rendered by Hospital that are the financial responsibility of the Health Network pursuant to the Health Network's contract with CalOptima.

2.20. **Linguistic and Cultural Sensitivity Services**. Hospital shall comply with CalOptima Policies and Laws related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Hospital shall address the special health needs of Members who are members of specific ethnic and cultural populations, including Vietnamese and Hispanic persons. Hospital shall, in its policies, administration, and services: (i) honor Members' beliefs,

traditions and customs; (ii) recognize individual differences within a culture; (iii) create an open, supportive and responsive organization in which differences are valued, respected, and managed; and (iv) through cultural diversity training, foster in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Hospital shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Hospital. Hospital shall provide translation of written materials in the threshold and concentration languages identified by CalOptima, as required by Laws, at no higher than the sixth (6th) grade reading level.

2.21. **Provision of Interpreters**.

2.21.1 Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Hospital shall comply with Health & Safety Code § 1259. To the extent that a CalOptima Member requires interpreter services beyond those mandated by Health & Safety Code § 1259 and to the extent that Hospital does not choose to provide such services, Hospital shall ensure that CalOptima is notified that the Member requires additional interpreter services, and CalOptima shall provide such services at its own expense. Interpreter services under this Section 2.21 include both linguistic interpreter services and interpreter services for the deaf and hard of hearing, as may be necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to this Contract, including Attachment C, CalOptima Policies, and Laws.

2.20.2 Hospital shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the friend or family member: (i) is requested by a Member; (ii) will not compromise the effectiveness of service; (iii) will not violate a Member's confidentiality; and (iv) Member is advised that an interpreter is available through CalOptima at no cost to the Member. Hospital may utilize interpreter services provided through the Cultural and Linguistic Coordinator within CalOptima's customer service department, as appropriate, at no charge to Hospital.

2.22. **CalOptima's Compliance Program and Other Guidance**. Hospital and its employees, board members, owners, Contracted Providers, and Subcontractors furnishing services under this Contract ("**Hospital Agents**") shall comply with the requirements of the Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Hospital and Hospital shall make them available to Hospital Agents. Hospital agrees to comply with, and be bound by, any and all MOUs.

2.23. **Equal Opportunity**. Hospital and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Hospital and its Subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. As applicable, Hospital and its Subcontractors will comply with all provisions of and furnish and post all information and reports required by Section 503 of the Rehabilitation Act of 1973 (as amended), the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212), and of the Federal Executive Order No. 11246 (as amended), including

by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Hospital and its Subcontractors will permit access to their books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

If Hospital or its Subcontractors do not comply with the provisions herein or with any applicable federal rules, regulations, or orders referenced herein, CalOptima may cancel, terminate, or suspend this Contract in whole or in part, and Hospital and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 (as amended), and such other sanctions and remedies provided under Laws.

Hospital and its Subcontractors will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor or other Laws. Hospital and its Subcontractors will take such action with respect to any subcontract or purchase order as directed by the Director of the Office of Federal Contract Compliance Programs or DHCS as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Hospital and its Subcontractors become involved in or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Hospital and its Subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.24. **Reporting Obligations**. In addition to any other reporting obligations under this Contract, Hospital shall submit such reports and data relating to services covered under this Contract as required by CalOptima, including, to comply with requests from Regulators.

2.25. **Subcontract Requirements**. If permitted by the terms of this Contract, Hospital may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Hospital under this Contract. Hospital must ensure that all Subcontracts are in writing, bind Subcontractors to all applicable provisions under this Contract, and incorporate all required provisions under this Contract or applicable Government Contracts. Any Hospital obligation under this Contract shall be deemed to include applicable Subcontractors. Hospital shall make all Subcontracts available to CalOptima or its Regulators upon request. Hospital is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Hospital shall require that all Subcontracts relating to the provision of Covered Services include provisions requiring the Subcontractor to do the following:

2.25.1 Make all books and records related to this Contract available at all reasonable times for inspection, examination, or copying by CalOptima or Regulators in accordance with Government Contract requirements and Laws.

2.25.2 Maintain such books and records (i) in accordance with the general standards applicable to such books and records and any record requirements in this Contract, Laws, Government Contracts, or CalOptima Policies; (ii) at the Subcontractor's place of business or at such other mutually agreeable location the State.

2.25.3 Comply with all Laws with respect to providing Emergency Services.

2.25.4 Notify Hospital of any investigations into Subcontractors' professional conduct or any suspension of or comment on a Subcontractor's Licenses, whether temporary or permanent.

2.25.5 Comply with the Compliance Program.

2.25.6 Comply with Member financial and hold harmless protections in this Contract and Laws.

2.26. **Fraud and Abuse Reporting**. Hospital shall report to CalOptima all cases of suspected FWA, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services, whether the cases relate to Hospital, Hospital's employees, Subcontractors, Contracted Providers, and/or Members, within five (5) Business Days of the date when Hospital first becomes aware of or is on notice of such activity.

2.27. **Participation Status**. Hospital shall have policies and procedures to verify the Participation Status of Hospital Agents. In addition, Hospital represents and warrants that:

2.27.1 Hospital and Hospital Agents shall meet CalOptima's Participation Status requirements during the Term.

2.27.2 Hospital shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment of Hospital or Hospital Agents occurring and/or discovered during the Term.

2.27.3 Hospital shall take immediate action (i) to prevent any Hospital Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract to Members; and (ii) take any other actions required by Regulators, Government Contracts, and/or Laws.

2.27.4 Hospital shall include the obligations of this Section 2.27 in its Subcontracts.

2.27.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Hospital shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.28. **Physical Access for Members**. Hospital shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**"), and Hospital and its Subcontractors shall ensure access for the disabled, which includes compliance with the ramps, elevators, restrooms, designated parking spaces, and drinking water requirements under the ADA.

2.29. **CLIA Laboratories**. Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number. Hospital shall ensure those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.30. **Member Rights**. Hospital shall ensure that each Member's rights, as set forth in Laws, Government Contracts, and CalOptima Policies, are fully respected and observed. Hospital will not retaliate or take any adverse action against a Member for exercising the Member's rights.

2.31. **Member Communication**. Hospital, acting in accordance with Laws, shall freely communicate with Members), regardless of benefit coverage limitations, about (i) their health status, medical care, or treatment options, including alternative treatments; (ii) the risks, benefits, and consequences of treatment or non-treatment; and (iii) a Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

2.32. **Electronic Transactions**. Hospital shall use best efforts to participate in electronic transactions with CalOptima, including electronic Claims submission, verification of eligibility, and enrollment, and submit electronic prior Authorization transactions in accordance with CalOptima Policies.

2.33. **Advance Directives**. Hospital shall maintain written policies and procedures related to Advance Directives and document patient records with respect to the existence of an Advance Directive in compliance with Laws. Hospital shall not discriminate against any Member based on that Member's Advance Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34. **WCM Program Compliance**. If Hospital is a CCS-authorized facility, then in the provision of CCS services to CalOptima Members, Hospital shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Hospital will use evidence-based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.35. **CCS Provider Compliance**.

2.35.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS-Eligible Condition requires treatment.

2.35.2 If Hospital is a CCS-Paneled Provider, Hospital agrees to provide services for the WCM Program in accordance with this Contract and CalOptima Policies.

2.33.2.1 Hospital shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.33.2.2 To ensure consistency in the provision of CCS Covered Services, Hospital shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Hospital shall use evidence-based guidelines or treatment protocols that are medically appropriate given Members' CCS Eligible Condition.

2.35.3 If Hospital is not a CCS-paneled hospital authorized by CCS to provide the specific CCS-eligible Services required by Members, Hospital agrees to cooperate with CalOptima in the transfer of Members with CCS eligible conditions to an appropriately authorized CCS-paneled Hospital.

2.36. **Admissions to LTC Facility**. Hospital shall plan the admission of Members to LTC Facilities, as required by CalOptima Policies. Hospital shall prospectively notify CalOptima of possible admissions to LTC Facilities and comply with the planning process for the assessment of Members

identified as needing long-term care. For Members assessed as appropriate for long long-term care, Hospital shall assist CalOptima as required to place Members in LTC Facilities contracted with CalOptima.

2.37. **Newborn Services**. For services provided to a child of a Medi-Cal Member during the month of birth or the following month, Hospital shall bill for such services in accordance with the Claim form completion instructions in the appropriate Medi-Cal Provider Manual relative to newborns.

2.38. **Members with Disabilities**. Hospital will accommodate inpatient and outpatient surgical and medical procedures for members with disabilities, including dental procedures under general anesthesia, to the extent that Hospital can provide such services.

2.39. **Data Sharing Technology for Discharge Planning**. Subject to compliance with all Laws, as well as this Contract, Hospital agrees to evaluate and implement the use of data sharing technology for purposes set forth in Health and Safety Code § 1262.5(n)(4)(A), (p), with respect to Members who are experiencing homeless, as defined in Health and Safety Code § 1262.4.

2.40. **Subcontract Terminations**. If a Subcontract terminates, Hospital shall ensure that there is no disruption in services provided to Members.

2.41. **Government Claims Act**. Subject to Section 9.13, Hospital shall ensure that Hospital and Hospital Agents comply with the applicable provisions of the Government Claims Act (California Government Code § 810 *et seq*.), including Government Code §§ 910 and 915, and CalOptima Policy AA.1217.

2.42. **Certification of Document and Data Submissions**. All data, information, and documentation provided by Hospital to CalOptima pursuant to this Contract shall be accompanied by a certification statement on the Hospital's letterhead signed by the Hospital's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.43. **CalOptima Oversight**. CalOptima is responsible for the monitoring and oversight of all obligations of Hospital under this Contract, and CalOptima has the authority and responsibility to: (i) implement, maintain, and enforce CalOptima Policies governing Hospital's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections, and/or investigations in order to oversee Hospital's performance of duties described in this Contract; (iii) require Hospital to take corrective action if CalOptima or a Regulator determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Hospital fails to meet CalOptima standards in the performance of that duty. Hospital shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima or its Regulators determine is necessary to comply with Laws, Government Contracts, Programs, Accreditation Organization standards, and/or CalOptima Policies.

2.44. **Conflicts of Interest**. Hospital shall comply with all CalOptima requirements and Laws pertaining to conflicts of interest, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.), and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

2.44.1 Hospital covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during their tenure has any interest, direct or indirect, in this

Contract or the proceeds thereof, in accordance with 22 CCR § 53600(d). Hospital further covenants that, for the Term, and consistent with the provisions of 22 CCR § 53600(f), no State officer or State employee shall be employed in a management or contractor position by Hospital within one (1) year after the State office or State employee has terminated State employment.

2.44.2 Hospital understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, Hospital will not be entitled to any compensation for services performed pursuant to this Contract, and Hospital will be required to reimburse CalOptima any sums paid to Hospital. Hospital further understands that Hospital may be subject to criminal prosecution for a violation of California Government Code § 1090.

2.44.3 If Hospital becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 2.44, Hospital shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

2.45. **Information and Cyber Security**. Hospital must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

2.45.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Provider's information systems and any CalOptima information that Hospital maintains or can access.

2.45.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Hospital maintains or can access.

2.45.3 Security. Safeguards for the security of the information systems and CalOptima information that Hospital maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

2.45.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

2.45.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

2.45.6 Notice. Hospital shall notify CalOptima by email (or by telephone if Hospital is unable to email CalOptima) within twenty four (24) hours of any use, disclosure, or access of Members' (i) protected health information (as that term is defined under 45 CFR § 160.103), (ii) personal information (as that term is defined under Civil Code § 1798.3(a), or (iii) medical information (as that term is defined under Civil Code § 56.05(j)) (collectively "**Protected Information**") that violates applicable laws and/or this Contract ("**Breach**").

2.45.7 Investigation. Hospital shall immediately investigate the Breach and report the following to CalOptima as soon as reasonably practicable:

2.45.7.1 The Breach details, including the date of the Breach and when it was discovered;

2.45.7.2 The identification of each Member whose Protected Information was accessed, used, or disclosed during the Breach;

2.45.7.3 The nature of the data elements involved and the extent of the data involved in the Breach;

2.45.7.4 A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed Protected Information;

2.45.7.5 A description of where the Protected Information is believed to have been improperly transmitted or utilized;

2.45.7.6 A description of the probable causes of the Breach;

2.45.7.7 Whether a law enforcement official has requested a delay in notification of individuals of the Breach because such notification would impede a criminal investigation or damage national security; and

2.45.7.8 Whether any federal or State laws requiring notifying individuals of breaches were triggered.

For the purpose of this Section 2.45, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 3
CALOPTIMA OBLIGATIONS

3.1. **Service Authorization**. CalOptima shall provide a written Authorization process for Hospital Covered Services pursuant to CalOptima Policies.

3.2. **CalOptima Guidance**. CalOptima shall make available to Hospital, on its website and upon request, all MOUs and CalOptima Policies applicable to Covered Services under this Contract.

3.3. **Member Eligibility**. CalOptima will maintain data on Member eligibility and enrollment and verify Member eligibility at the reasonable request of a Provider. CalOptima shall ensure Members are provided identification cards identifying Members as enrolled in the applicable Program. CalOptima shall ensure Members are provided identification cards identifying Members as enrolled in the applicable Program. CalOptima shall ensure Members are provided with identification cards identifying Members as enrolled in the applicable Program.

3.4. **Care Management**. CalOptima shall provide care management services for Members.

3.5. **Member Materials**. CalOptima shall furnish Hospital any written materials that CalOptima wants Hospital to provide to Members, including translations into threshold languages at appropriate grade level.

ARTICLE 4
PAYMENT PROCEDURES

4.1. **Payment**. CalOptima shall pay Hospital for Covered Services provided to Members as provided in CalOptima Policies and Attachment B. Hospital agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Notwithstanding the foregoing, Hospital may also collect other amounts (*e.g.*, SOC and/or third-party liability payments) where expressly authorized to do so under the Program(s) and Laws.

4.2. **Billing and Claims Submission**. Hospital shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.3. **Prompt Payment**. CalOptima shall pay Hospital in the time and manner set forth in Attachment B, CalOptima Policies, and Laws.

4.4. **Limitations of CalOptima's Payment Obligations**. Notwithstanding anything to the contrary in this Contract, CalOptima's obligation to pay Hospital any amounts shall be subject to CalOptima's receipt of the funding from the federal and/or State governments.

4.5. **Claim Completion and Accuracy**. Hospital shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms, tape, or electronically including Claims submitted for the Hospital by other parties. Use of a billing Agent does not abrogate Hospital's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Hospital acknowledges that Hospital remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.6. **Claims Deficiencies**. CalOptima shall deny any Claim that fails to meet CalOptima requirements for Claims processing and notify Hospital of the denial pursuant to CalOptima Policies and Laws.

4.7. **Coordination of Benefits**. Hospital shall practice COB with other programs or entitlements, recognizing where CalOptima is not the primary coverage, in accordance with Program requirements. Hospital acknowledges that Medi-Cal is the payor of last resort.

4.8. **Member Financial Protections**. Hospital and its Subcontractors shall comply with Member financial protections as follows:

4.8.1 Hospital agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Hospital for any amounts which are owed by, or are the obligation of, CalOptima.

4.8.2 In no event, including nonpayment by CalOptima, CalOptima's or the Hospital's insolvency, or breach of this Contract by CalOptima, shall the Hospital or any of its Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State or any Member or person acting on the behalf of a Member for Covered Services pursuant to this Contract.

Notwithstanding the foregoing, Hospital may collect SOC if, and to the extent, required under the applicable Program and/or Laws.

4.8.3 This provision does not prohibit Hospital or its Subcontractors from billing and collecting payment for non-Covered Services if Hospital provides written notice to the Member prior to providing the services of what services are non-Covered Services and the cost of those non-Covered Services and the Member agrees to the payment in writing prior to the actual delivery of non-Covered Services. Hospital must give a copy of such agreement to the Member and place in the Member's Medical Records prior to rendering such services.

4.8.4 Upon receiving notice of Hospital invoicing or balance billing a Member for the difference between the Hospital's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Hospital or take other action as provided in this Contract or allowed under Laws, including reimbursing the Member for such a balance bill and deducting the reimbursement amount from any payments otherwise owed to Hospital.

4.8.5 This Section 4.8 shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Hospital and its Subcontractors. Hospital shall ensure the substance of this Section 4.8 is included in all Subcontracts.

4.9. **Overpayments**. Hospital must immediately report any Overpayment identified by Hospital and to repay such Overpayment to CalOptima within sixty (60) days of such identification by Hospital or of receipt of notice of an Overpayment identified by CalOptima or any other entity.

4.10. **Offset**. If CalOptima determines that an Overpayment has occurred, CalOptima shall have the right to recover such amounts from Hospital by offset from current or future amounts due from CalOptima to Hospital under this Contract or any other arrangement between the Parties, after giving Hospital notice and an opportunity to return/pay such amounts in accordance with Section 4.9 and the procedures, including the interest rates for untimely reimbursements, set forth in Health & Safety Code § 1371.1(a). This right to offset shall include:

4.10.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

4.10.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

4.10.3 Unpaid Conlan reimbursements owed by Hospital to a Member.

4.10.4 Payments made for services provided by a Hospital that entered into a private contract with a Medicare beneficiary for Covered Services.

4.11. **Rate Adjustments**. CalOptima may adjust the payment rates under Attachment B during the Term to account for implementation of federal or State laws or regulations; changes in the State budget, Government Contract(s), or Regulators' policies; and/or changes in in the scope of Covered Services. CalOptima shall provide notice thereof to Hospital as soon as practicable of any such changes, and such adjustments shall comply with Laws.

4.11. **Taxes and Contributions**. As applicable and required by Laws, Hospital shall be responsible for withholding and paying all federal, State, and local taxes and contributions regarding (i) Hospital's earnings under this Contract, (ii) the salaries or other benefits paid or made available to any persons retained or employed by Hospital to furnish services under the Contract, or (iii) otherwise related to Provider's services under this Contract.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1. **Indemnification**. Each Party agrees to defend, indemnify, and hold each other and the State harmless with respect to any claims, costs, damages and expenses, including reasonable attorneys' fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party of any functions, duties, or obligations of the Party under this Contract.

5.2. **Insurance Requirements**.

5.2.1 Professional Liability. Hospital, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least $5,000,000 per incident/$5,000,000 aggregate per year. CalOptima is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against CalOptima are to be waived.

5.2.2 Hospital Commercial General Liability/Commercial Crime Liability/Automobile Liability. Hospital, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Hospital; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.2.1 Commercial General Liability of $1,000,000 per incident/$3,000,000 aggregate per year.

5.2.2.2 Commercial Crime Liability of $250,000 aggregate per year.

5.2.2.3 Automobile Liability of $1,000,000 per incident/$3,000,000 aggregate per year.

5.1.1 Workers Compensation Insurance. Hospital, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of $1,000,000 per each accident/$1,000,000 injury policy limit/$1,000,000 injury per employee.

5.1.2 Cyber Liability Insurance. Hospital, at its sole cost and expense, shall maintain cyber lability insurance with the following minimum limits for covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: $1,000,000 each occurrence/claim and $1,000,000 aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification

expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

5.2 **Insurer Ratings**. Such insurance will be secured and maintained at Hospital's own expense. All above insurance shall be provided by an insurer:

5.2.1 With an A.M. Best rating of A-VII or better; and

5.2.2 "Admitted" to conduct business in the State, an insurer approved to do business in the State by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers, or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.3 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned in this Article 5 are provided by a captive risk retention group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the captive risk retention group's or self-insured's audited financial statements and approves the waiver.

5.4 **Cancellation or Material Change**. Hospital shall not, of its own initiative, cause such insurances as addressed in this Article 5 to be canceled or materially changed during the Term.

5.5 **Certificates of Insurance**. Prior to execution of this Contract, upon any change or renewal of insurance policies under this Article 5, or at CalOptima's request, Hospital shall provide Certificates of Insurance to CalOptima showing the insurance coverage required under this Article 5 and further providing that (i) CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder; and (ii) coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.6 **Failure to Maintain Insurance**. If Hospital fails or refuses to maintain or produce proof of the insurance required by this Article 5, CalOptima shall have the right, at its election, to terminate this Contract immediately upon written notice to Hospital. Such termination shall not affect Hospital's right to be paid for its time and materials expended prior to notification of termination.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1. **Access to and Audit of Contract Records**. Hospital and its Subcontractors shall allow CalOptima, Regulators, and/or their duly authorized Agents and representatives access to books and records related to services provided under the Contract, including Medical Records, contracts, documents, and electronic systems. Hospital shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Hospital's operations and to inspect, audit, and reproduce all records and materials and to verify Claims and reports submitted under this Contract. Provider shall maintain records in chronological sequence and in an immediately retrievable form in accordance with the Laws applicable to such record keeping. If a Regulator determines there is a reasonable possibility of fraud or similar risk, the Regulator may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, the Regulator reserves the right to suspend or terminate Hospital and its Subcontractors from participation in the applicable Program; seek recovery of payments made to

Provider; and impose other sanctions, and CalOptima may terminate this Contract immediately due to fraud.

6.2. **Medical Records**. As applicable to Covered Services, Hospital and its Subcontractors shall establish and maintain, for each Member who has obtained Covered Services, Medical Records organized in a manner to contain such demographic and clinical information as necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with Laws, Program requirements, Government Contracts, and CalOptima Policies and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, Hospital. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Hospital, to readily determine the nature and extent of the Member's medical problem and the services provided and to permit peer review of the care furnished to the Member. In accordance with Laws, Provider shall provide copies of Medical Records to other treating or consulting providers (i) to facilitate a Member's continuity of care, including Member transfers; (ii) when a Member seeks a second opinion on a diagnosis or treatment of a medical condition; or (iii) when such disclosure is necessary for a Member to access Medi-Cal or Medicare-covered services.

6.1 **Records Retention**. Hospital shall maintain books and records in accordance with the time and manner requirements set forth in Laws and Programs, including as identified in Attachment D. When Hospital furnishes Covered Services to a Member in more than one Program with different record retention periods, then the greater record retention requirement shall apply.

6.2 **Audit, Review, and/or Duplication**. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Laws concerning confidentiality and ownership of records. Hospital shall pay all duplication and mailing costs associated with such audits.

6.3 **Confidentiality of Member Information**. Hospital agrees to comply with Laws governing the confidentiality of Member medical and other information. Hospital further agrees:

6.3.1 Privacy and Security Requirements. Hospital shall comply with all Privacy Requirements. Hospital shall also take actions and develop capabilities as required to support CalOptima compliance with Privacy Requirements, including acceptance and generation of applicable electronic files in HIPAA-compliant standards formats.

6.3.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with Laws. Hospital shall protect from unauthorized disclosure all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4 **Data Submission**. Hospital shall submit to CalOptima complete, accurate, reasonable, and timely Hospital data, Encounter Data, and other data and reports needed by CalOptima to meet its reporting requirements to Regulators, including DHCS and CMS, and as set forth in CalOptima Policies.

ARTICLE 7
TERM AND TERMINATION

7.1. **Term**. The term of this Contract shall begin on the Effective Date and continue in effect for [five (5) years] ("**Initial Term**"). The Contract then shall automatically renew for [five (5)] one (1)-year terms (each a "**Renewal Term**"), unless otherwise terminated under this Article 7 or directed by CalOptima's Board of Directors. The Initial Term and any Renewal Terms together constitute the "**Term**" of this Contract.

7.2. **Termination for Default**. CalOptima may, in its sole discretion, terminate this Contract if CalOptima determines that Hospital or any Subcontractor (i) has failed to perform its contracted duties and responsibilities in a timely and proper manner, including the service procedures and standards identified in this Contract, (ii) has committed acts that discriminate against Members on the basis of their health status or requirements for health care services; (iii) has not provided Covered Services in the scope or manner required under this Contract; (iv) has engaged in prohibited marketing activities; (v) has failed to comply with the Compliance Program; or (vi) has materially breached any other covenant, condition, or term of this Contract (each a "**Termination for Breach**"). In the event of a Termination for Breach, CalOptima shall give Hospital prior written notice of its intent to terminate with a thirty (30)-day cure period, if the Termination for Breach is curable, in the sole discretion of CalOptima. If Hospital does not cure the Termination for Breach within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Section 7.2 are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. Hospital shall not be relieved of its liability to CalOptima for damages sustained by virtue of the Contract breach by Hospital or any Subcontractor.

7.3. **Termination for Non-Payment**. Hospital may terminate the Contract if CalOptima fails to pay Hospital for Covered Services, as required under the Contract ("**Non-Payment**"). In the event of Non-Payment, Hospital shall give CalOptima prior written notice of its intent with a thirty (30)-day cure period. If CalOptima does not cure the Non-Payment within the thirty (30)-day cure period, Hospital may terminate the Contract immediately following such thirty (30)-day period.

7.4. **Immediate Termination**. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice:

7.4.1 The suspension or revocation of any License required for Hospital and/or Hospital Agents to provide services under this Contract;

7.4.2 CalOptima's determination that the health, safety, or welfare of Members is jeopardized by continuation of this Contract;

7.4.3 The imposition of sanctions or disciplinary action against Hospital or against Hospital Agents in their capacities with Hospital by any federal or state licensing agency;

7.4.4 Hospital's failure to comply with Participation Status requirements;

7.4.5 Hospital has committed FWA or permitted FWA in connection with Hospital's obligations under the Contract;

7.4.6 CalOptima reasonably determines that Hospital's facility, equipment, or personnel are insufficient to provide Covered Services;

7.4.7 Hospital violates any Laws or is indicted;

7.4.8 Hospital or its Contracted Providers fail to meet Minimum Standards and/or maintain the Licenses required to provide Covered Services;

7.4.9 Hospital fails to satisfy the terms of a corrective action plan issued by CalOptima under this Contract;

7.4.10 Termination or non-renewal of any Government Contract;

7.4.11 Termination is required by a Regulator; or

7.4.12 The withdrawal of HHS's approval of the waiver granted to CalOptima under Section 1915(b) of the SSA. If CalOptima receives notice of termination from any Regulators or termination of the Section 1915(b) waiver, CalOptima shall immediately notify Hospital.

7.5. **Termination for Insolvency**. If Hospital, Hospital's parent or holding company, or a Subcontractor becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, Hospital shall immediately notify CalOptima, and CalOptima may immediately terminate the Contract at its sole option upon written notice to Hospital. In the event of the filing of a petition for bankruptcy by or against Hospital, Hospital's parent or holding company, or a principal Subcontractor, Hospital shall ensure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract. If CalOptima becomes insolvent, Hospital will have the right to terminate the Contract immediately upon written notice to CalOptima

7.6. **Termination Without Cause**. After the Initial Term, either Party may terminate this Contract without cause upon [insert number of days] (XX) days' prior written notice to the other Party.

7.7. **Obligations Upon Termination**. Upon termination of this Contract, Hospital shall continue to provide Authorized Covered Services to Members who retain eligibility and who are under the care of Hospital at the time of such termination until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Hospital shall continue to provide Covered Services to hospitalized Members in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from Hospital or alternate coverage is arranged for by CalOptima. Payment for services under this Section 7.7 shall be at the contracted rates in effect under the Contract immediately prior to termination. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Regulators to assist in the orderly transfer of Members' medical care, Hospital shall make available to CalOptima and/or such Regulators copies of any pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members. The provision of or payment for services after the termination of the Contract shall not be construed as a renewal of this Contract for any further term or a rescission of any Contract termination.

7.8. **Survival**. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 2.26 (Fraud and Abuse Reporting), 2.30 (Member Rights), 4.8 (Member Financial Protections), 4.9 (Overpayments), 4.10 (Offset), 5.1 (Indemnification), 6.1 (Access to Audit of Contract Records), 6.2 (Records Retention), 6.3 (Audit, Review, and/or Duplication) 6.4 (Confidentiality of Member Information), 6.5 (Data Submission), 7.7 (Obligations Upon Termination), 7.8 (Survival), Article 8 (Grievances and Appeals), 9.5 (Governing Law and Venue),

9.7 (No Liability of the County of Orange), 9.13 (Dispute Resolution), 9.14 (Interpretation), and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1. **Hospital Grievances**. CalOptima has established a fast and cost-effective system for provider complaints, grievances, and appeals ("**PDR System**"). Hospital shall have access to this PDR System for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable Program. Hospital shall attempt to resolve any complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract through the PDR System and exhaust all remedies under the PDR System prior to proceeding to arbitration under Section 9.13.

8.2. **Member Grievances and Appeals**. Hospital agrees to cooperate in the investigation of any Member grievances, complaints, and appeals and be bound by CalOptima's decisions and, if applicable, State and/or federal hearing decisions or any subsequent appeals. Provider shall also continue providing services to a Member, if requested by CalOptima and the Member, until any grievance or appeal from a Member regarding Provider is resolved.

ARTICLE 9
GENERAL PROVISIONS

9.1 **Assignment, Assumption, and Change of Control**. Hospital may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1, assignment includes: (i) the change of more than fifty percent (50%) of the directors or trustees of Hospital; (ii) the merger, reorganization, or consolidation of Hospital with another entity when Hospital is not the surviving entity; or (iii) a change in the management of Hospital from management by persons appointed, elected or otherwise selected by the governing body of Hospital (*e.g.*, the Board of Directors) to a third-party management person or entity. In addition, Hospital must obtain CalOptima's prior written consent for any change of control. For purposes of this Section 9.1, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions).

9.2 **Entire Agreement**. This Contract, including its attachments, addenda, exhibits, and amendments and all CalOptima Policies applicable to Covered Services (and any amendments thereto), constitutes the entire agreement between the Parties and supersedes and terminates any previous agreements between the Parties. All prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract not expressly set forth herein shall be of no further force, effect, or legal consequence after the Effective Date.

9.3 **Amendments**. CalOptima reserves the right to amend or terminate the Contract at any time when such modifications or terminations are (i) mandated by changes in Laws, (b) required by Government Contracts; or (ii) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall promptly notify Hospital in writing of such Regulatory Changes and in accordance with applicable federal and/or State requirements, and Hospital shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a Regulator, including DHCS. Notwithstanding

a Regulatory Change, any other amendment of a term to this Contract must be in writing and executed by the Parties unless otherwise permitted or required by Laws.

9.4 **Force Majeure**. Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including an act of war, and excluding labor disputes. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

9.5 **Governing Law and Venue**. This Contract shall be governed by and construed in accordance with all laws of the State, federal laws, and regulations applicable to the Programs, and all contractual obligations of CalOptima. Subject to the restrictions in Section 9.13, Hospital shall bring any and all legal proceedings against CalOptima under this Contract in California State courts in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

9.6 **Independent Contractor Relationship**. Hospital, and any Agents or employees of Hospital in performance of this Contract, shall act in an independent capacity and not as officers, employees, or Agents of CalOptima. Hospital's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Hospital's personnel performing services under this Contract shall be at all times under Hospital's exclusive direction and control and shall be employees and/or Agents of Hospital, and CalOptima. Hospital shall pay all wages, salaries, and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 **Names and Marks**. Hospital shall not use the name, logo or other proprietary mark of CalOptima in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining CalOptima's express written approval of the material and consent to such use.

9.8 **No Liability of the County of Orange**. As required under County Ordinance No. 3896, as amended, the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County shall have no obligation or liability therefore.

9.9 **No Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in writing and signed and dated by the Parties.

9.10 **Notices**. Any notice required under this Contract, unless otherwise indicated herein, shall be in writing and sent by certified or registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Attn: Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Hospital:

{{*Name on Notice_es_:signer1: }}
Name
{{*Title on Notice_es_:signer1: }}
Title
{{*Address on Notice_es_:signer1 }}
Address

9.11 **Prohibited Interests**. Hospital covenants that, for the Term, no director, Member, officer, or employee of CalOptima during his/her tenure has any personal interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 **Authority to Execute**. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract, the Parties are formally bound.

9.13 **Severability**. If any provision of this Contract is rendered invalid or unenforceable by Laws or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect as though the invalid or unenforceable parts had not been included herein.

9.14 **Dispute Resolution**.

9.14.1 Meet and Confer. For any dispute not subject to or resolved by the Hospital appeals process, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 9.13.2.

9.14.2 Arbitration. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.13.1, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties cannot agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four

potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

9.14.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.13.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the Hospital appeals or meet-and-confer processes. Notwithstanding the foregoing, either Party may institute proceedings in a federal or state court of competent jurisdiction to seek temporary or preliminary injunctive relief to enforce the status quo in any dispute relating to this Contract pending the resolution of that dispute through arbitration.

9.14.4 Limitations Period. Hospital acknowledges that Government Code § 911.2 requires a claim against a government entity to be brought no later than one (1) year after the accrual of the cause of action. As such, the Parties agree that arbitration under Section 9.13.2 must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, the dispute will be deemed waived, and the complaining Party shall be barred from initiating arbitration or other proceedings related to the dispute, including any civil action in state or federal court. For disputes related to Claims, the one (1)-year limitations period under this Section 9.13.4 shall begin to run as of the final Claim denial date under CalOptima's Hospital appeals system. If Hospital fails to participate in any portion of CalOptima's Hospital appeals system for a disputed Claim, as described in Section 8.1, Hospital waives its right to arbitrate that claim. The deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

9.14.5 Waiver. By agreeing to binding arbitration as set forth in Section 9.13.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

9.15 **Injunctive Relief**. If Hospital breaches any provision of this Contract, CalOptima shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Contract, including injunctive relief without the necessity of posting bond.

9.16 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Contract, and no implication shall be drawn against any Party by virtue of the drafting of this Contract.

9.17 **Without Limitation**. The words "include", "includes", and "including" are not words of limitation and shall be deemed to be followed by the phrase "without limitation".

9.18 **Recitals and Exhibits**. The recitals, attachments, exhibits, and/or addenda set forth in this Contract are made a part of the Contract by this reference.

ARTICLE 10
EXECUTION

10.1 **Execution**. This Contract may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument. Subject to the State and United States providing funding during the Term and for the purposes with respect to which it is entered into, execution of the Government Contracts, and the approval of the Contract by Regulators, this Contract shall become effective as of the Effective Date

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Hospital	CalOptima
_____ Signature _____ Print Name _____ Title _____ Date	_____ Signature _____ Print Name _____ Title _____ Date

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
PROGRAMS

1.1. Programs. Hospital shall participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**MSSP**
[Y/N]	**PACE**
[Y/N]	**Covered California**

ARTICLE 2
COVERED SERVICES

2.1. Hospital is responsible for providing the following Covered Services, as Authorized by CalOptima or its designee with the exception of Emergency Services, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary:

2.1.1 Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2.1.2 Hospitalization in an intensive care unit or special care unit;
2.1.3 Pediatric services;
2.1.4 Maternity services;
2.1.5 Psychiatric and substance abuse services;
2.1.6 Newborn nursery, all levels;
2.1.7 Ancillary services and supplies, including laboratory and radiology services;
2.1.8 Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
2.1.9 Emergency Services;
2.1.10 Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s);
2.1.11 Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives;
2.1.12 Tranplant surgical services and organ acquisition, if applicable; and
2.1.13 Other hospital Covered Services that Hospital is properly licensed to provide.

ATTACHMENT B
COMPENSATION

CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

I. General Compensation Requirements

1.1 All billing and reimbursement must be in accordance with applicable Program, Government Contract, and Regulator payment guidelines, including Medi-Cal and Medicare.

1.2 Inpatient admissions to Hospital prior to the effective date of any rate amendment to this Attachment B, where a Member is still inpatient on the date of the rate amendment, shall be paid at the rates in place under this Contract at the time of admission for the entire length of the stay.

1.3 CalOptima may revise the rates in this Attachment B, in accordance with Laws, during the Term to reflect changes in Laws, the State budget, or compensation under the Government Contracts. CalOptima shall provide written notice to Hospital as soon as practicable upon becoming aware of the change.

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II. Medi-Cal

2.1. Inpatient Facility Services: 125% of Hospital's then-current Medi-Cal program APR-DRG rate.

2.2. Inpatient Acute Administrative Days: 100% of the Medi-Cal fee schedule rate and per CalOptima Policies regarding the criteria for authorizing acute administrative days.

2.3. Outpatient Services (excluding drugs):

Hospital Service	Qualifying Codes	Fee Schedule Multiplier
Observation status	HCPCS Z7514	240% Medi-Cal FFS
Emergency room	HCPCS Z7502	240% Medi-Cal FFS
Operating room	HCPCS Z7506	240% Medi-Cal FFS
GI lab	Revenue codes 075X	240% Medi-Cal FFS

*All claims for outpatient services are subject to Notes in subsections b) and c) of this Section II.

2.4. Outpatient Services – All other (excluding drugs): 140% of Medi-Cal fee schedule rates.

2.5. Outpatient Administered Drugs: 100% of Medi-Cal fee schedule rates.

2.6. Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, Hospital will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Hospital

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be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Medi-Cal Program requirements, Laws, and CalOptima Policies.

Notes:

a) Inpatient services include Emergency Services when a Member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive.

b) Conditions and terms applicable to the fee schedule multipliers:

i. Outpatient drugs, blood, and blood products are excluded line items from the above fee schedule multiplier and paid at 100% of the Medi-Cal fee schedule.
ii. Outpatient services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.
iii. The default outpatient Medi-Cal fee schedule multiplier is 140%. To qualify for a higher payment multiplier, the qualifying code(s) must be present and payable on the claim.
iv. For outpatient claims that meet multiple hospital service categories, the highest Medi-Cal fee schedule multiplier applies to the entire claim except for excluded line items paid at 100% of the Medi-Cal fee schedule.
v. The fee schedule multiplier for emergency department services is inclusive of any trauma activation team.

c) Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

III. OneCare

3.1 Inpatient Acute Care: 100% of Medicare fee schedule

3.2 Outpatient Care: 100% of Medicare fee schedule

Notes:

a) For Medicare Part A or Part B services provided to OneCare Members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

b) All physician fees are excluded from these OneCare rates.

IV. PACE

4.1 Inpatient Acute Care: 100% of Medicare fee schedule

4.2 Outpatient Care: 100% of Medicare fee schedule

Notes:

a) For Medicare Part A or Part B services provided to CalOptima PACE Members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

b) All physician fees are excluded from these PACE rates.

V. Payment Procedures

5.1 Claims Submission. Hospital shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Hospital may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Hospital shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Hospital is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Hospital is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Hospital is solely responsible for reimbursing its Contracted Hospitals for providing Covered Services for Hospital under this Contract and shall ensure that all Contracted Hospitals agree to accept payment from Hospital as payment in full for Covered Services provided to Members.

5.2 Payment Codes and Modifiers. Hospital shall utilize current payment codes and modifiers for Med-Cal when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

5.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Hospital for additional justification, and these will be handled on a case-by-case basis.

5.4 Prompt Payment. CalOptima shall make payments to Hospital in the time and manner set forth in CalOptima Policies and Laws.

5.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Hospital of any denial pursuant to CalOptima Policies and Laws.

5.6 Claims Auditing. Hospital acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Hospital and its Contracted Hospitals will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

5.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Hospital in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims

for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

ATTACHMENT C
PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

1.1 **CalOptima Responsibilities**. CalOptima shall provide Members with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Hospital pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth herein.

1.2 **Request for Interpretation Services**. To request interpretation services for a Member, Hospital shall, at least one (1) week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic ("**C&L**") Coordinator. CalOptima requires the following information at the time of the request:

1.2.1 Member name and ID, date of birth, and telephone number;

1.2.2 Name and phone number of the caretaker, if applicable;

1.2.3 Language or sign language needed;

1.2.4 Date and time of the appointment;

1.2.5 Address and telephone number of the facility where the appointment is to take place;

1.2.6 Estimated amount of time the interpretation service will be needed; and

1.2.7 Type of appointment: assessment, fitting/delivery, or other.

1.3 **Hospital's Responsibilities**.

1.3.1 C&L Coordinator. CalOptima C&L Coordinator will make best efforts to secure an interpreter within seventy-two (72) hours of a request and will confirm the results of this effort to Hospital and Member.

1.3.2 Appointment Changes. If there is any change with the appointment, Hospital shall contact C&L Coordinator at least seventy-two (72) hours before the scheduled appointment.

1.3.3 Hospital Obligation for Cost. If Hospital fails to communicate with C&L Coordinator an interpretation request or change to an interpretation request more than seventy-two (72) hours before the appointment, Hospital will incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 **Health Network Contact**. For Health Network Members, Hospital shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT D
REGULATORY REQUIREMENTS

The following additional terms and conditions contained in the following regulatory addenda apply to items and services furnished to Members under the Programs listed in Attachment A. If these terms conflict with those elsewhere in the Contract, the terms from the applicable addendum in this Attachment D shall control with respect to the Program at issue.

[*include the regulatory addendums for the Programs listed in Attachment A*]

Medi-Cal Program Addendum

This Medi-Cal Addendum shall apply to the Medi-Cal Program and (and to the OneCare Program (where applicable to D-SNP). For avoidance of doubt, this addendum does not apply to CalOptima's PACE, MSSP, or Covered California Programs.

1. **Definitions**.

   1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Hospital's and Subcontractor's duties and obligations under the Contract.

   1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

   1.3 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

   1.4 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment D.

   1.5 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws and government program requirements.

2. **Compliance with Laws**. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including the Knox Keene Act, Health and Safety ("**H&S**") Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq*., 53900 *et seq*. Hospital will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Hospital shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. **Provider Data**. As applicable, Hospital and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Hospital shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. Hospital will make corrections to provider data as requested by CalOptima. Hospital data shall include all data required under the Contract – including reports and provider rosters. For purposes of this section, (1) "**Program Data**" means data that includes Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. **Encounter Data**. As applicable, Hospital will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data needed by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Hospital will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. **Reports**. Hospital and its Subcontractors agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. **California Health and Human Services ("CalHHS") Data Exchange**. Hospital shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"); (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [H&S Code § 130290; DHCS Contract, Exhibit A, Attachment III § 3.1.5(A)(21), (B)(30)]

7. **Additional Subcontracting Requirements**. If Hospital is allowed to subcontract services under this Contract and does so subcontract, then Hospital shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

    7.1 Subcontracts for Provision of Covered Services. Hospital shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. Hospital will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

    7.2 Subcontracts. Hospital shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

        7.2.1 The services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor per unit of service.

7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment D that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify Hospital of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. **Records Retention**. Hospital and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Hospital's books and records shall be maintained within, or be otherwise accessible, within the State and pursuant to Health & Safety Code § 1381(b). Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima and/or representatives of any regulatory or law enforcement agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4.D, 3.1.5(A.9) and (B.14); H&S Code § 1381; 28 CCR 1300.81]

9. **Access to Books and Records**. Hospital agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or Hospital and its Subcontractors; (ii) at all reasonable times at Hospital's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the

general standards applicable to such book or record keeping. Hospital and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Hospital, CalOptima reserves the right to suspend or terminate the Hospital from participation in the Medi-Cal program; immediately suspend payments to Hospital; seek recovery of payments made to Hospital or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

As permitted under Laws, Hospital and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by Regulators, including DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation Hospital may possess in order to verify Hospital's records.

This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5 (A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Hospital shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information subject to any lawful privileges, in Hospital's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Hospital agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Hospital acknowledges that time is of the essence in responding to such requests. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Hospital or its Subcontractors related to this Contract or Subcontracts. Hospital further agrees to timely gather, preserve, and provide to DHCS any records in Hospital's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. **Transfer**. Hospital agrees and will require its Subcontractors to assist CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. **Unsatisfactory Performance**. Hospital agrees that the Contract or Hospital's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that Hospital has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. **Hold Harmless**. Hospital and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. Hospital and

its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Hospital pursuant to this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. **Prohibition on Member Claims and Member Billing**. Hospital and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Hospital and its Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14); 3.3.6; 5.2.7]

15. **Prospective Requirements**. CalOptima will inform Hospital of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Hospital's obligations before the requirement becomes effective. Hospital agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by CalOptima or DHCS. Hospital will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective; and (ii) agree to comply with new requirements within thirty (30) days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. **Network Provider Training**. Hospital shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis, and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Hospital shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Hospital shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24); 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. Hospital shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to Hospital with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

    16.3 Discharge Planning and Transitional Care Training. Hospital will educate its discharge planning staff on the services, supplies, medications, and durable medical equipment requiring prior authorization, and CalOptima's policies regarding discharge planning and transitional care services, as applicable. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10(A.6) and (A.7)]

17. **Language Assistance and Interpreter Services**. Hospital and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. Hospital agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25); 5.1.3(F)]

18. **Fraud, Waste, and Abuse Reporting**. Hospital shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. Hospital agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Hospital information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Hospital acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26),]

19. **Provider Identified Overpayments**. In addition to Overpayment requirements under the Contract, Hospital shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date Hospital identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19) and (B.27)]

20. **Health Care Providers' Bill of Rights**. Notwithstanding anything in this Contract to the contrary, Hospital shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. **Provider Grievances**. Hospital has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code §1367(h)(1). CalOptima's process to resolve Hospital disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. **Effective Dates**. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. **Assignment and Sub-delegation**. Hospital agrees that any assignment or delegation of an obligation or responsibility under this Contract by Hospital to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Hospital further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. **Quality Improvement & Utilization Management**. Hospital agrees to cooperate and participate in CalOptima's quality improvement and management programs, including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. **Emergency Services and Post-Stabilization**. Responsibility for coverage and payment of Emergency Services and Post-Stabilization Care services have not been delegated to Hospital under the Contract. "**Post-Stabilization Care**" means "Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized in accordance with 42 CFR § 438.114 and 28 CCR § 1300.71.4. Hospital's provision of Post-Stabilization Care shall comply with Laws and CalOptima Policies, including for UM and Authorization. [42 CFR § 438.114; 28 CCR § 1300.71.4; DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)].

26. **Telehealth**. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Hospital shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; Welfare & Institutions Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different Provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable under the Contract if Hospital did not comply with these Telehealth Requirements.

27. **Electronic Prescriptions**. Hospital and any Subcontractors who may issue prescriptions under Business & Professions Code § 4040(a) shall have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. **Amendment and Termination**. Hospital agrees that CalOptima shall notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. **Delegated Activities**. If Hospital is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, Claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Hospital, to the extent agreed upon between CalOptima and Hospital. Hospital agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Hospital agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Hospital has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Hospital; (ii) CalOptima's oversight, monitoring, and evaluation processes and Hospital's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Hospital's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Hospital's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. **Utilization Data**. If and to the extent that Hospital is responsible for the coordination of care for Members, CalOptima shall share with Hospital any utilization data that DHCS has provided to CalOptima, and Hospital shall receive the utilization data provided by CalOptima and use it solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. **Medical Decisions**. Hospital will ensure that medical decisions or any course of treatment in the provision of Covered Services by Hospital, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. **Capacity, Licensure, and Enrollment**. Hospital and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Hospital and Subcontractor is authorized to provide under this Contract, consistent with the scope of Hospital's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. Hospital and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Hospital warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. **Medi-Cal Enrollment**. If Hospital is a provider type that is not able to enroll in Medi-Cal through the DHCS, Hospital shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35.

34. **Prohibition Against Payment to Excluded Providers**. Hospital agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Hospital if Hospital is excluded from State or federal programs. Hospital further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. **Ownership Disclosure Statement**. Prior to commencing services under this Contract, Hospital shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Hospital holding more than five percent (5%) of the stock issued by Hospital, and major creditors holding more than five percent (5%) of the debt of Hospital by accurately completing the Disclosure Form provided by CalOptima and included in CalOptima Policy EE1141. Hospital shall promptly notify CalOptima whenever changes occur to the information provided in the Disclosure Form. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    35.1 If a Subcontractor is not eligible to enroll in Medi-Cal, Hospital shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35 for the Subcontractor.

36. **Performance Improvement Projects**. Hospital and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. **No Punitive Action**. CalOptima will not take punitive action against Hospital if Hospital requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the

risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. **Claims Processing**. CalOptima will process Claims in accordance with the DHCS Contract, H&S §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If Hospital is responsible for Claims payments, Hospital will pay Claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

39. **Cost Avoidance/Other Health Coverage**. Hospital acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay Claims for services provided to a Member who has third-party coverage without proof that Hospital has first exhausted all other payment sources. Hospital shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. Hospital shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Hospital must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. **Public Record**. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. **Provider Preventable Condition**. CalOptima will not pay Hospital for a provider preventable condition as described in 42 C.F.R. § 438.3(g). As a condition of payment, provider shall comply with reporting requirements on provider preventable conditions in the form and frequency required by DHCS in APL 17-009 or any superseding APL. If Hospital is delegated Claims payments, Hospital will ensure it does not pay for provider preventable conditions. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. **Member Rights**. Hospital and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. **Medical Records**. All medical records shall be maintained in accordance with CalOptima Policies. Hospital shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. **Timely Access/Standards of Accessibility**. Hospital and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Hospital and Subcontractors will comply with CalOptima's procedures for monitoring Hospital's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. **Minor Consent Services**. Hospital and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Hospital and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. **Emergency Preparedness Requirements**. Hospital agrees to cooperate with and comply with CalOptima's Emergency requirements, policies and procedures, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Hospital will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Hospital's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if Hospital closes down, is unable to meet the demands of a medical surge or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

47. **State's Right to Monitor**. Hospital and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Hospital's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Hospital, Subcontractor, and Hospital's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Hospital. Access will be undertaken in such a manner as to not unduly delay the work of the Hospital and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. **Laboratory Testing**. Hospital agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. **Third Party Tort Liability**. Hospital and Subcontractors shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. Hospital shall identify and notify CalOptima, within five (5) days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. **Changes in Availability or Location of Services**. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Hospital's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. **Confidentiality of Medi-Cal Members**.

51.1 Hospital and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq*. Hospital and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as Welfare & Institutions Code § 14100.2 and regulations adopted thereunder, Hospital and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Hospital, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Hospital and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

51.2.1 Hospital and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Hospital may release medical records in accordance with Laws pertaining to the release of this type of information. Hospital is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Hospital or its Subcontractors, Hospital will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Hospital by CalOptima for this purpose.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. **Debarment Certification**. By signing this Contract, Hospital agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

52.1 By signing this Contract, Hospital certifies to the best of its knowledge and belief, that it and its principals:

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

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing

a public (federal, state, or local) transaction or contract under a public transaction; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

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

52.1.7 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

52.2 If the Hospital is unable to certify to any of the statements in this Section 52, Hospital shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the Hospital knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. **DHCS Directions**. If required by DHCS, Hospital and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34]

54. **Lobbying Restrictions and Disclosure Certification**.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, Hospital shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment E prior to the Effective Date.

54.2 **Certification and Disclosure Requirements**.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Hospital shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 Hospital shall file a disclosure (in the form set forth in Attachment E entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Hospital has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 Hospital shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Hospital under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

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

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

54.2.4 Each Subcontractor who requests or receives from Hospital or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

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

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of one hundred thousand dollars ($100,000) must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Hospital agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 et seq.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. **Smoke-Free Workplace**. Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Hospital shall comply with the applicable requirements of the Pro-Children Act. Hospital further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. **Domestic Partners**. Pursuant to H&S Code § 1261, if Hospital is licensed pursuant to H&S Code § 1250, Hospital agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

58. **Conflict of Interest**. Hospital agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict-of-interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) working days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. **DHCS Beneficiary**. Hospital expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. **Employment Non-Discrimination**. During the performance of this Contract, neither Hospital nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Hospital and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this

Contract by reference and made a part hereof as if set forth in full. Hospital and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Hospital shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

60.1 Hospital and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. Hospital and all Subcontractors shall comply with California nondiscrimination requirements, including the Unruh Civil Rights Act, GC sections 7405 and 11135, Welfare & Institutions Code § 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. **Member Non-Discrimination**. Neither Hospital nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

61.1 Hospital shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

61.2 Hospital shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

61.3 Hospital shall require all Subcontractors to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E § 1.1.30]

62. **Program Integrity and Compliance Program**. Hospital will comply with CalOptima's program integrity and compliance program. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. **Federally Qualified Health Centers ("FQHC"), Rural Health Centers ("RHC"), or Indian Health Services ("IHS") Facility**.

63.1 If Hospital is an FQHC or an RHC, Hospital will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including (i) submitting documentation of services provided, reimbursement level, and payment amounts; (ii) certifying that this Contract is offered to Hospital on the same terms and conditions as those offered to other network providers providing similar services and that reimbursement is not less than the level and amount of payment which the entity would make for the service if they were furnished by a provider that is not an FQHC; and (iii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

63.2 If Hospital is an FQHC or an RHC, Hospital acknowledges and agrees that CalOptima is not required to pay Hospital the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that Hospital and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

63.3 To the extent Hospital is an Indian Health Services facility that qualifies as an FQHC and RHC; Hospital agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to Hospital.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

64. **Admission, Discharge, and Transfer ("ADT")**. If Hospital maintains electronic health records, Hospital shall send ADT notifications to CalOptima for each Member served by Hospital in accordance with the Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the CalHHS Data Exchange Framework set forth in H&S § 130290, and as further specified in the DHCS Population Health Management Policy Guide. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10 (A)(9)]

OneCare Program Addendum

This OneCare Addendum shall only apply to the OneCare Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, PACE, MSSP, or Covered California Programs.

1. **Hold Harmless**. Hospital agrees to hold harmless Members in case CalOptima cannot or will not pay for services under the Contract. This provision shall not prohibit collection of any applicable SOC billed in accordance with the terms of Members' evidence of coverage. Hospital further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of Members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Hospital and Members or persons acting on their behalf that relates to liability for payment for Covered Services.

2. **Accountability**. Any services or other activity under the Contract performed by Hospital and any of its Subcontractors will be performed in accordance with CalOptima's contractual obligations to CMS and DHCS, including the requirements at 42 C.F.R. § 438.414 in relation to the grievance system.

3. **Coordination of Benefits Requirements**. Hospital shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible. Hospital agrees to establish procedures to effectively identify, at the time of service and as part of their Claims payment procedures, individuals and services for which there may be a financially responsible party other than Medicare and the OneCare Program. Hospital will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

4. **Submission and Prompt Payment of Claims**. Hospital agrees to submit Claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny Claims that are not submitted within ninety (90) days of the date of service. CalOptima shall provide payment to Hospital within forty-five (45) Business Days of CalOptima's receipt of a Clean Claim from Hospital, or CalOptima will contest or deny Hospital's Claim within forty-five (45) Business Days following CalOptima's receipt thereof.

5. **Claims Payment**. CalOptima will not pay Hospital for a Hospital preventable condition. As a condition of payment, Hospital will comply with the applicable reporting requirements on Hospital preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by CalOptima or DHCS. Hospital shall comply with such reporting requirements to the extent that Hospital directly furnishes services.

6. **Cost-Sharing**. Hospital agrees that Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members. Hospital and any of its contracted Hospitals must not impose cost-sharing requirements on Members that would exceed the amounts permitted under the Medi-Cal Program, 42 U.S.C. § 1395w-22(a)(7), and 42 C.F.R. section 422.504(g)(1)(iii). Hospital shall (i) accept reimbursement from CalOptima under the Contract as payment in full for services rendered to Members, or (ii) bill Member's Medi-Cal managed care health plan, as applicable and in accordance with Laws, for any additional Medicare payments that may be reimbursed by Medi-Cal. Hospital will also comply with requirements outlined in W&I Code § 14019.4 related to Medi-Cal services.

7. **Federal Funds**. Hospital acknowledges that payments Hospital receives from CalOptima are, in whole or part, from federal funds. Therefore, Hospital and any of its Subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the ADA; Section 504 of the

Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, and any other regulations applicable to recipients of federal funds.

8. **Compliance with Medicare Laws**. Hospital will comply with all applicable federal and State laws (including Medicare laws), regulations, and CMS instructions, including laws and regulations designed to prevent or ameliorate FWA, including applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 *et seq*.), and the anti-kickback statute (Section 1128(B)(b) of the SSA), and HIPAA administrative simplification rules at 45 C.F.R. Parts 160, 162 and 164. Further, Hospital agrees that any services provided by Hospital will be consistent with and will comply with CalOptima's contract with CMS ("**CMS Contract**").

9. **Language Assistance**. Hospital will provide services in a culturally competent manner and agrees to arrange for the provision of interpreter services for Members at all Hospital sites.

10. **Reporting**. Hospital agrees to provide relevant reports, data, and information necessary for CalOptima to meet its obligations under the OneCare Program and Laws, including 42 CFR §§ 422.516 and 422.310. In addition, Hospital shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by Hospital, whether by Hospital, Hospital's employees, Subcontractors, and/or Members within five (5) working days of the date when Hospital first becomes aware of or is on notice of such activity.

11. **Offshore Activities**. Unless CalOptima has provided prior written authorization, all services provided by Hospital pursuant to the Contract must be performed within the United States, the District of Columbia, or the United States territories.

12. **Excluded Individuals/Program Integrity**. Hospital acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to the Contract with any individual or entity (hereafter, "**Person**") whom Hospital knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the SSA. Hospital hereby certifies that no such excluded Person currently is employed by or under contract with Hospital. Hospital shall ensure that the Persons it employs or contracts for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, as defined in 42 CFR § 422.2. Hospital shall promptly after discovery disclose to CalOptima any exclusion, or other event that makes a Hospital employee or downstream entity ineligible to perform work related to federal health care programs, in accordance with 42 CFR § 422.752(a)(8). Hospital agrees to be bound by the provisions set forth at 2 CFR Part 376.

13. **Emergency Medical Treatment and Labor Act**. Hospital must comply with the federal Emergency Medical Treatment and Labor Act ("**EMTALA**"), as applicable, and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

14. **Punitive Action**. CalOptima will not take punitive action against Hospital if Hospital requests an expedited resolution or supports a Member's appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information a Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for a Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

15. **Indemnity**. Hospital is not required to indemnify CalOptima for any expenses and liabilities, including judgments, settlements, attorney's fees, court costs, and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, other policies, guidelines, or actions.

PACE Program Addendum

This MSSP Addendum shall only apply to the MSSP Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, Medicare, PACE, or Covered California Programs.

1. **Definitions**. PACE is a program that features a comprehensive medical and social services delivery system using an interdisciplinary team ("**IDT**") approach in an adult day health center that is supplemented by in-home and referral services, in accordance with Members' needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of Members and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima. PACE services shall include the following:

    1.1 All Medicare-covered items and services;

    1.2 All Medi-Cal-covered items and services; and

    1.3 Other services determined necessary by the IDT to improve and maintain the Members' overall health statuses.

2. **State Termination**.

    2.1 CalOptima may terminate the Contract as it applies to providing services to Members if CalOptima's PACE Agreement or DHCS Contract with DHCS terminates for any reason. CalOptima shall notify Hospital of any such termination immediately upon its provision of notice of termination of the PACE Agreement or DHCS Contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS or CMS, or the DHCS Contract from DHCS.

3. **Hospital Responsibilities**.

    3.1 Service Area. Hospital shall make PACE services available at a location accessible to Members within the County.

    3.2 Services Authorized. Hospital shall furnish only those services Authorized by the CalOptima PACE IDT. A primary care Hospital referral is deemed an IDT Authorization.

    3.3 Interdisciplinary Team Meeting Participation. If necessary for the benefit of Member care delivery or planning, Hospital shall participate in CalOptima PACE IDT meetings. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

    3.4 Payment in Full. Hospital shall accept CalOptima's payment as payment in full for services provided to Members and shall not seek any reimbursement for services directly from Members, Medi-Cal, Medicare, or another insurance carrier or Hospital. Hospital shall not seek any type of cost-share amount from Members for PACE Covered Services. Members

shall not be liable to Hospital for any sum owed by CalOptima, and Hospital agrees not to maintain any action at law or in equity against Members to collect sums that are owed by CalOptima. Surcharges to Members by Hospital are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Hospital shall reimburse Members as appropriate.

3.5 Hold Harmless. Hospital will not bill the State, CMS, or Members if CalOptima does not pay for services performed by Hospital pursuant to the Contract.

3.6 Reporting. Hospital shall provide such information and written reports to CalOptima, DHCS, and HHS as may be necessary for compliance by CalOptima with its statutory obligations and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

3.7 Coverage of Non-Network Providers. Hospital agrees that should arrangements be made by Hospital with another Provider that is not contracted with CalOptima to provide Covered Services required under the Contract, such Provider shall (a) accept payment from Hospital as full payment for services delivered to Members, (b) comply with the applicable provisions of the Contract, (c) only bill services to Hospital's office, unless Hospital has made other billing arrangements with CalOptima, (d) not bill Members under any circumstances, and (e) cooperate with and participate in CalOptima's quality assurance and improvement program.

3.8 Compliance with the Law. Hospital shall comply with the applicable provisions of 42 CFR Part 460, including 42 CFR § 460.70.

4. **Hospital Personnel**.

4.1 Hospital shall ensure its employees and Contracted Hospitals providing direct patient care to PACE Members comply with all State and federal requirements for direct patient care staff in their respective setting, including:

4.1.2 Having not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or social service programs under Title XX of the SSA;

4.1.3 Not a pose any potential risk to Members because of conviction or physical, sexual, drug or alcohol abuse;

4.1.4 Be free of communicable diseases; and

4.1.5 Agree to abide by the requirements, philosophy, practices and protocols of CalOptima's PACE Program and 22 CCR § 78413.

4.2 Hospital shall provide documentation within one (1) Business Day to CalOptima, upon request, a list of all Hospital personnel employed or contracted with during the requested period, including first and last name, job title, date of hire, date of termination (if terminated within the requested period), type of employment (full-time, part-time, volunteer, contractor, or other), and whether the position required a license.

4.3 Hospital shall ensure its records contain the following for each employee:

4.3.1 An employment application, a full name, social security number, date of employment, date of birth, home address, educational background, and previous employment experience, including dates employed.

4.3.2 Proof that each employee received in-service training in first aid and in cardiopulmonary resuscitation within the first six (6) months of employment.

4.3.3 A background check completed prior to the employee's date of hire.

4.3.4 An OIG exclusion check completed prior to their date of hire.

4.3.5 Documentation that each employee has current and active licensure if licensure is required for their position.

4.3.6 A chest x-ray or test for tuberculosis infection for each employee, as recommended by the federal Centers for Disease Control and Prevention and licensed by the federal Food and Drug Administration, performed not more than twelve (12) months prior to employment or within seven (7) days of employment.

4.3.7 A health examination signed by the examining physician or person lawfully authorized to perform such examination which indicates the employee is physically qualified to perform duties, is free from any condition that would create a hazard to self or others, and medically cleared of communicable diseases before engaging in direct Member contact.

4.3.8 Documentation that each employee completed the following CalOptima trainings:

4.3.8.1 Orientation to the PACE Program, including the Member Bill of Rights, service determination requests, and the grievance and appeals processes.

4.3.8.2 Skills competencies completed both ***before*** providing any independent care to Members, as well as annually.

4.4. Hospital shall have written policies implementing the requirements of this Section 4 and retain employee records pertaining to this Section 4 for at least three (3) years following termination of each employee's employment.

5. **PACE Liaison**. CalOptima PACE Program director or their designee shall be designated as the liaison to coordinate activities between Hospital and CalOptima.

6. **Records**. Hospital shall retain PACE Program records for the latter of (i) ten (10) years from the final date of the DHCS Contract or the date of completion of any audit; or (ii) ten (10) years from the close of the current fiscal year in which the service occurred, in which the record or data was created or applied, and for which the financial record was created, unless a longer period is required by Laws.

This provision shall survive the expiration or termination of the Contract, whether with or without cause, by rescission, or otherwise.

7. **Assignment and Delegation**. The Contract is not assignable, nor are the duties hereunder delegable, by the Hospital, either in whole or in part, without the prior written consent of CalOptima

and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima.

8. **Third Party Tort Liability/Estate Recovery**. Hospital shall make no claim for the recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall inform CalOptima of potential third-party liability claims and provide information relative to potential third-party liability claims, in accordance with CalOptima Policies.

9. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Hospital shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its subcontractors' possession relating to threatened or pending litigation by or against CalOptima or DHCS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Hospital or its subcontractors related to the Contract or subcontracts.

10. **DHCS Policies**. Covered Services provided under the Contract shall comply with all applicable requirements of the Medi-Cal Program and the DHCS Integrated Systems of Care Division ("**ISCD**") (or any successor division to the ISCD).

11. **DHCS Directions**. If required by DHCS, Hospital and its Subcontractors shall cease specified activities, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

12. **Turnover and Phase-Out Requirement**. Hospital agrees that, upon termination of the DHCS Contract between CalOptima and DHCS, Hospital shall make available to CalOptima and DHCS copies of Medical Records, Member files, and any other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. Hospital further agrees to assist CalOptima with phase-out for the DHCS Contract, which consists of the resolution of all financial and reporting obligations of CalOptima.

13. **Reporting Unusual Incidents or Occurrences**. Hospital shall report to CalOptima within twenty-four (24) hours any unusual incidents, injuries, or occurrences of which Hospital becomes aware relating to Members. For purposes of this section, an unusual incident or injury is one that threatens the welfare, safety or health of any Member and that is not consistent with Hospital's routine operation or patient care practices, including a fire, explosion, epidemic outbreak, poisoning, catastrophe, major accident, or like event that occurs in or on the premises of Hospital's office or facility which threatens welfare, safety or health of Members.

14. **Emergency Services and Post-Stabilization Delegation**. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Hospital under the Contract.

15. **DHCS Monitoring**. Hospital shall comply with all monitoring provisions in CalOptima's contract with DHCS and any monitoring requests by DHCS.

Covered California Program Addendum

This Covered California Addendum shall only apply to the Covered California Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, MSSP, or PACE Programs.

1. **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Covered California Program Addendum.

   1.1. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("**QHP**") issuer to provide administrative services or health care services to qualified individuals and their dependents.

   1.2. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

   1.3. **Emergency Medical Condition** means the same as the definition of "emergency medical condition" set forth in HSC § 1317.1(b).

   1.4. **Emergency Services** means those Covered Services for inpatient and outpatient care services, as specified in HSC § 1317.1(a), furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize a Member's Emergency Medical Condition.

   1.5. **Medically Necessary** and **Medical Necessity** means the reasonable and necessary Covered Services needed to prevent, diagnoses, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

2. **Compliance.** Hospital agrees to be bound by all provisions of the Qualified Health Plan Issuer Contract between CalOptima and Covered California ("**QHP Contract**") that are applicable to the services Hospital provides to CalOptima and its Members. Hospital agrees to comply with all Laws, including the federal Patient Protection and Affordable Care Act, (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), known collectively as the Affordable Care Act; the California Patient Protection and Affordable Care Act, Assembly Bill 1602 and Senate Bill 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010); the Americans with Disabilities Act of 1990 (42 USC §§ 12101 *et seq*.); the Anti-Kickback Statute (42 USC § 1320a–7b); the Public Contracts Anti-Kickback Act (41 USC §§ 51 *et seq*.); the Stark Law (42 USC § 1395nn); the Knox- Keene Health Care Service Plan Act of 1975 (HSC §§ 1340 *et seq*.); the Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq*.); all Laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code); Public Contract Code Section 10295.3 with regard to benefits for domestic partners; environmental laws, rules, and regulations applicable to its operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30 (commencing with Section 42460 of the Public Resources Code) relating to hazardous and solid waste; and any and all other State and federal Laws, rules, and regulations applicable to the operation of Covered California, the QHP Contract, and Hospital's provision of services under the Contract. Hospital will incorporate such applicable requirements in Hospital's contracts with its Subcontractors, including the provisions under §4.4.1(d) of the QHP

Contract. [QHP Contract §§ 1.2(c), 1.3(b), 1.13, 4.4.1(b)-(d)]

3. **Nondiscrimination in Administration of Services and Benefits.** Hospital and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557 (42 USC § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d *et seq*.), Title IX of the Education Amendments of 1972 (20 USC §§ 1681 *et seq*.), the Age Discrimination Act of 1975 (42 USC §§ 6101 *et seq*.), Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), or subject to any other applicable Laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health Product or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xv), 1.10(a)]

4. **Conflict of Interest.** Hospital agrees to be free from any conflicts of interest with respect to Covered Services provided under the Contract. Hospital and its personnel shall not currently have, and shall not have throughout the Term, any direct interest that may present a conflict in any manner with the performance of services required under the Contract. Hospital represents that it is not aware of any conflict of interest or any basis for potential violations with respect to Laws that govern referrals required for the provision of certain Covered Services, including federal and State Anti-Kickback and Anti-Self-Referral Laws. [QHP §§ 4.4.1(d)(xvi), 1.11]

5. **Nondiscrimination in Workplace.** Hospital and its agents, employees, and Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome, mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), aged forty (40) or over, marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Hospital and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Hospital and its agents and employees shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 10000 *et seq*.). The applicable regulations of the California Fair Employment and Housing Commission implementing Government Code § 12900, set forth in California Code of Regulations Chapter 5 of Division 4 of Title 2, including 2 CCR §§ 11102 *et seq*., are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]

6. **Privacy and Security Requirements for Personally Identifiable Data.** Hospital agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 USC §§ 1320d *et seq*., HITECH, and any current and future regulations promulgated under HIPAA or HITECH, all as amended from time to time and collectively referred to herein as the "**HIPAA Requirements**." Hospital agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this section that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(a); 45 CFR § 155.260(b)(2)(v)]

   6.1. Hospital shall, and shall require that its Subcontractors, maintain technology policies and procedures acceptable to CalOptima that provide reasonable safeguards to protect Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Hospital and its Subcontractors. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(e)]

   6.2. Hospital shall, and shall require that its Subcontractors, comply with all applicable Exchange

Protection of Information policies, in accordance with the terms and conditions set forth in Section 10.2 of the QHP Contract, Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(h), 10.2]

6.3. If Hospital will have access to Protected Health Information and/or Personally Identifiable Information that is received from, created, or received by CalOptima on behalf of Covered California or in connection with the QHP Contract, Hospital agrees to be bound by the same or more stringent restrictions, terms, and conditions as those that apply to CalOptima pursuant to the QHP Contract with respect to such Protected Health Information and Personally Identifiable Information, provided, however, that any restrictions that are more stringent shall be set forth in the Contract. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(i)]

6.4. Hospital shall mitigate to the extent practicable, any harmful effect that is known to Hospital of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Hospital in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(f)]

6.5. Hospital shall cooperate with Covered California in investigating any Breach and/or successful Security Incident involving Protected Health Information and/or Personally Identifiable Information and in meeting Covered California's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving Protected Health Information and/or Personally Identifiable Information is attributable to Hospital, Hospital shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and CalOptima. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(e)(iii)]

6.6. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of CalOptima, Hospital agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR Part 162. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(iv)]

6.7. Hospital shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Hospital or its Subcontractors or agents, including (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) State law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of the Breach and to respond to the Breach; (b) mitigate harm to the affected Individual(s); and (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(vi)]

7. **State Agency Reviews**. Hospital agrees that Covered California, the California Department of General Services, State Auditors, other State and federal regulatory agencies, or their designated representatives shall, subject to applicable Laws regarding the confidentiality and release of Protected Heath Information of Members, have the right to review and to copy any records and supporting documentation pertaining to the performance of the QHP Contract. Hospital agrees to

maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. Hospital agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(xxii), 11.5(c)]

8. **Performance Measurement Standards.** Hospital shall comply with all QHP Contract requirements and performance measurement standards, including those related to customer service that are applicable to Covered Services. CalOptima shall provide the performance measurement standards to Hospital. CalOptima may impose penalties for failure to comply or otherwise act in accordance with applicable performance standards of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xix), Article 7]

9. **Medical Records.** Except with respect to any longer periods that may be required under Laws, Hospital will maintain a Medical Record documentation system adequate to fully disclose and document the medical condition of each Member, to the extent applicable to the services, and the extent of Covered Services provided to each Member by Hospital. Medical Records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by Laws, if an audit, litigation, research, evaluation, claim, or other action involving records has not concluded before the end of the seven (7)-year minimum retention period, Hospital shall retain the Medical Records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(i) & (xxii), 11.1]

10. **Claims Data**. Hospital shall cooperate with CalOptima's obligations under the QHP Contract to maintain historical Claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from the date that the QHP Contract is terminated with respect to Covered Services provided to Members during the term of the QHP Contract. These records shall include the data elements required to produce specific reports mutually agreed upon by Covered California and CalOptima and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable Regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductibles, out-of-pocket costs, and other cost-sharing for each Claim. [QHP Contract §§ 4.4.1(d)(xiv) and (xii), 11.2(c)]

11. **Financial Records**. Financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by Hospital in connection with the QHP Contract shall be retained by Hospital for at least ten (10) years from the date of the final Claims payment, unless a longer maintenance period is required by Laws or the QHP Contract. Hospital shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to Hospital. This shall include: (i) adequate data customarily maintained and reasonably necessary to properly document each of Hospital's transactions with CalOptima during the period the QHP Contract remains in force; and (ii) records of Claims, including medical review and high dollar special audit Claims. [QHP Contract §§ 1.12, 4.4.1(d)(xiv), (xxii), 11.2(a), 11.2(b)]

12. **Books and Records Location**. Books and records shall be kept in a secure location at Hospital's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by CalOptima, Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10)-year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), 11.3]

13. **Notice.** Hospital shall promptly notify CalOptima in writing of any inquiry, audit, investigation,

litigation, claim, examination, or other proceeding involving Hospital, personnel, or Subcontractors that is threatened or commenced by any governmental authority or other party that a reasonable person might believe could materially affect the ability of CalOptima to perform in accordance with the terms set forth in the QHP Contract. [QHP Contract §§ 4.4.1(d)(xxii), 11.6]

14. **Scope of Licensure**. All Covered Services must be provided by duly licensed, certified, or accredited providers consistent with the scope of their Licenses and in accordance with applicable Laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in this Contract and the QHP Contract. [QHP Contract § 4.4.1(a)]

15. **QHP Contract Requirements**. Hospital agrees to be bound, and to bind each of its Subcontractors, by all provisions of the QHP Contract that are applicable to the Covered Services that Hospital and its Subcontractors provide under the Contract [QHP Contract § 4.4.1(d)], including:

    15.1. Coordination with Covered California and other programs and stakeholders.

    15.2. Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and CalOptima's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].

    15.3. Participating Hospital directory requirements [QHP Contract § 4.4.4].

    15.4. Symphony Hospital directory requirements [QHP Contract § 4.4.5)].

    15.5. Implementation of processes to enhance stability and minimize disruption to the provider network [QHP Contract § 4.3.3].

    15.6. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].

    15.7. Hospital credentialing, including maintenance of licensure and insurance [QHP Contract § 3.4.2].

    15.8. Customer service standards [QHP Contract § 4.6].

    15.9. Utilization managements processes [QHP Contract § 5.3].

    15.10. Maintenance of a corporate compliance program [QHP Contract § 1.2].

    15.11. Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].

    15.12. Appeals and grievances [QHP Contract § 4.6.2].

    15.13. Member and marketing materials [QHP Contract § 3.2].

    15.14. Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.12], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].

    15.15. Nondiscrimination [QHP Contract § 1.10].

    15.16. Conflict of interest and integrity [QHP Contract § 1.11].

    15.17. Other Laws [QHP Contract § 1.13].

    15.18. Advancing equity, quality, and value to the extent applicable to Participating Hospitals [QHP Contract Article 5], including disclosure of contracting arrangements with Participating Hospitals as required pursuant to Attachment 1, Advancing Equity, Quality, and Value, to the QHP Contract.

    15.19. Performance measures, to the extent applicable to Participating Hospitals [QHP Contract Article 7].

15.20. Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.3 and Article 8].

15.21. Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].

15.22. Maintenance of books and records [QHP Contract Article 11].

16. **Cooperation**. Hospital recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, CalOptima, Hospital, and any other authorized Subcontractors. Hospital shall coordinate and cooperate with CalOptima and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. Hospital shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of the California Healthcare Eligibility, Enrollment, and Retention System with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other Laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.6]

17. **Subcontractor Selection**. Hospital shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any CalOptima approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable Laws, rules, regulatory requirements, and orders. Hospital's obligations pursuant to this Contract and applicable Laws shall not be waived or released if Hospital is permitted to subcontract or otherwise delegate services of this Contract. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]

18. **Independent Contractors**. Nothing in the QHP Contract or this Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Hospital or CalOptima and Hospital. The Parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]

19. **Hospital Directory**. Hospital shall provide information to CalOptima to allow CalOptima to comply with its provider directory obligations under the QHP Contract. Hospital acknowledges that Covered California may use Hospital's data for any noncommercial purposes. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

20. **Member Liability**. Hospital shall comply with Laws governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if CalOptima fails to pay an amount owed by CalOptima to Hospital. Hospital shall inform every Member in a manner that allows the Member the opportunity to act upon Hospital's proposal or recommendation regarding (i) the use of a non-Participating Hospital or (ii) the referral of a Member to a non-Participating Hospital for proposed non-Emergency Services. Hospital shall disclose to a Member considering accessing non-Emergency Services from a Participating Hospital if a non-Participating Hospital will be used as part of the Participating Hospital's plan of care. Hospital is responsible for complying with the Hospital Manual and may rely upon the provider directory of CalOptima in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]

21. **Credentialing**. If Hospital is delegating activities relating to credentialing and re-credentialing, the process used by Hospital must be reviewed and approved by CalOptima and as otherwise required by DMHC or any other applicable Regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]

22. **Utilization Management**. Hospital shall cooperate and comply with and participate in the UM Program established by CalOptima in compliance with Laws, including HSC § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]

23. **Eligibility and Enrollment Determinations**. Hospital shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to CalOptima in its

efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2, Article 3]

24. **Grievances and Appeals**. Hospital shall cooperate and comply with the internal review process established by CalOptima to resolve Member written or oral grievances and appeals, including those involving expressions of dissatisfaction regarding Hospital. Hospital shall comply with State and federal Laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2]

25. **Quality, Network Management, and Delivery System Standards**. Hospital shall cooperate and comply with programs established by CalOptima consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to CalOptima to ensure CalOptima's compliance with its required reporting obligations pursuant to Attachment 1, Advancing Equity, Quality, and Value, of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]

26. **Customer Service Standards**. Hospital shall comply with all applicable QHP Contract customer service standards that are applicable to Hospital. [QHP Contract §§ 4.4.1(d)(viii), 4.6]

27. **Continuity of Care**. Hospital agrees to comply with policies and procedures implemented by CalOptima to enhance stability and minimize disruption to CalOptima's provider networks. Hospital shall provide CalOptima with the information necessary to comply with notice and other requirements in the cases of block transfers (HSC § 1373.65) and network disruptions (HSC §§ 1373.23 and 1366.1). In the event of a change related to network disruption, block transfers, or other similar circumstances, Hospital shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under Laws, including those relating to continuity of care set forth at HSC § 1373.95 and as otherwise set forth in the QHP Contract. In the event of termination of the QHP Contract or decertification of one or more of CalOptima's QHPs, Hospital shall cooperate fully with CalOptima and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(xx), 4.3.3, Article 8]

28. **Fraud, Waste, and Abuse Programs**. Hospital shall maintain compliance and provide CalOptima with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance of its obligations and CalOptima's reporting obligations under the QHP Contract. [QHP Contract §§ 4.4.1(d)(x), 1.2, 1.15]

29. **Insurance**. Hospital shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable Laws. [QHP Contract § 9.1.3]

30. **No Surprises Act**. Hospital shall comply with the rules against surprise billing in the Consolidated Appropriations Act of 2021 (the "**No Surprises Act**"), including complying with applicable cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections. If Hospital is responsible for processing Claims for Covered Services rendered by out-of-network providers, Hospital shall process such Claims in accordance with the No Surprises Act. [HSC § 1371.9; 45 CFR §§ 149.410, 149.420, 149.430, 149.440]

31. **CalOptima Accountability.** Notwithstanding any relationship CalOptima may have with Hospital, as Delegated Entity, and any Downstream Entity, CalOptima maintains responsibility for its compliance, as well as the compliance of the Hospital and any Downstream Entity, with all applicable standards enumerated at 45 CFR § 156.340(a). [45 CFR § 156.340(a)]

32. **Delegated Entity and Downstream Entity Compliance.** If any of CalOptima's issuer activities and obligations, in accordance with 45 CFR § 156.340(a), are delegated to Hospital, then Hospital, as Delegated Entity, agrees to the following provisions and Hospital further agrees that it will require Downstream Entities to comply with the same standards. [45 CFR § 156.340(b)]

32.1. **Standards for Downstream and Delegated Entities.** The Contract, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. [45 CFR § 156.340(b)(1)]

32.2. **Revocation of Delegated Activities.** In the event the HHS or CalOptima determines, in its sole discretion, that Hospital or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR § 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or CalOptima, as applicable. [45 CFR § 156.340(b)(2)]

32.3. **Compliance with Laws.** Hospital will perform such activities and obligations in compliance with all applicable Laws and regulations relating to the standards specified in 45 CFR §156.340(a). [45 CFR § 156.340(b)(3)]

32.4. **Right to Audit.** Hospital and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the OIG, or their designees, to evaluate through audit, inspection, or other means, Hospital's or the Downstream Entity's books, contracts, computers, or other electronic systems, including Medical Records and documentation, relating to CalOptima's obligations in accordance with the standards enumerated at 45 CFR § 156.340(a), as applicable, until ten (10) years from the final date of the Contract period. [45 CFR § 156.340(b)(4)-(5)]

33. **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits CalOptima from entering into a contract with Hospital, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict CalOptima from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or Members, or individuals eligible to become participants, beneficiaries, or Members of the plan or coverage; (ii) electronically accessing de-identified Claims and Encounter Data for each participant, beneficiary, or Member; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Contract, Hospital agrees that CalOptima is in compliance with this provision with respect to this Contract and nothing in this Contract will prohibit CalOptima from complying with this provision.

Knox-Keene Act Addendum

This Knox-Keene Act Addendum shall only apply to the Program(s) governed by the Knox-Keene Act and regulated by the DMHC. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, or PACE Programs.

1. **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of Health & Safety Code ("**HSC**") 1367.03 and 28 CCR § 1300.67.2.2 and in a manner that provides continuity of care, including the availability of PCPs who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or Hospital to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and State Laws.

Hospital shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Hospital has any role in rendering Emergency Services, Hospital will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Hospital shall provide reporting required by CalOptima and DMHC necessary to ensure compliance with DMHC accessibility and network adequacy standards. Hospital will comply with CalOptima's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments. [HSC §§ 1367, 1367.03, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]

2. **Licensure and Certification**. As applicable, Hospital and its employed and contracted personnel shall be licensed and certified by their respective board or agency, where licensure or certification is required by law to provide services under the Contract. As applicable, any equipment used by Hospital and/or its employed and contracted personnel under the Contract required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. [H&S Code § 1367(b)-(c)]

3. **Coordination of Member Care.** Hospital is responsible for coordinating the provision of health care services to a Member if Hospital is acting as the Member's PCP. Hospital shall maintain Member Medical Records in a readily available manner that permits sharing with CalOptima of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]

4. **Hospital Directory Information.** Hospital shall inform CalOptima within five (5) Business Days of material changes that would affect Hospital's or its Contracted Hospitals' listing in CalOptima's provider directory, so that CalOptima can comply with HSC § 1367.27. Material changes include:

   4.1. The addition or deletion of a Contracted Hospital from Hospital's group of providers.

   4.2. A change in Hospital's or a Contracted Hospital's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.

   4.3. Whether Hospital or its Contracted Hospitals are or are not accepting new patients.

   If Hospital or one of its Contracted Hospitals is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Hospital shall direct the Member or potential Member to CalOptima for additional assistance in finding a provider and to DMHC to report any inaccuracy with CalOptima's directories.

   Hospital shall provide to CalOptima any information necessary for CalOptima to comply with State Laws. If Hospital does not comply with this provision or demonstrates a pattern of repeated failure, CalOptima may terminate the Contract. [HSC § 1367.27]

5. **Notices to Members of Termination or Block Transfer.** Hospital shall cooperate and assist CalOptima in fulfilling CalOptima's obligations under 28 CCR § 1300.67.1.3 regarding block transfer filings with the DMHC. Any written communications to Members that concern a termination of this Contract or block transfer shall comply with the notification requirements in HSC § 1373.65(f). CalOptima shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]

6. **Continuation of Care after Termination for Certain Conditions.** If the Contract is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Hospital will, at the request of the Member and CalOptima, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Hospital prior to

termination, including the rate of compensation. Reimbursement for such services will be at the applicable rates listed in Attachment B, *Compensation*. Upon termination of the Contract, CalOptima is liable for the Covered Services rendered by Hospital (other than any permissible co-payments, co-insurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Hospital's care at the time of termination of the Contract until the Covered Services the Hospital is rendering to the Member are completed or until CalOptima makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Hospital. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]

7. **Quality Assurance Program.** CalOptima will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Hospital will assist CalOptima in maintaining CalOptima's quality assurance program, as applicable, and consistent with CalOptima's quality assurance program policies and procedures. To the extent that any of CalOptima's quality assurance functions are delegated to Hospital, Hospital shall promptly deliver to CalOptima all information requested for the purpose of monitoring and evaluating Hospital's performance of those quality assurance functions and so that CalOptima may comply with Laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2(d), 1300.70]

8. **No Inducement to Deny Covered Services.** Hospital acknowledges and agrees that this Contract does ***not*** (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Hospital to induce Hospital to provide care to Members in a manner inconsistent with coverage requirements. Hospital shall ensure that its contracts with individual providers similarly comply with this Section 8. [HSC §§ 1348.6, 1367.62(a)(3)]

9. **Appeals and Grievances of Members.** CalOptima will be responsible for resolving Member appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. CalOptima's process to resolve provider grievances are set forth in the Contract and CalOptima Policies. Hospital will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Hospital shall assist and cooperate with CalOptima in responding to Member grievances and requests for independent medical reviews consistent with CalOptima Policies, including the Hospital Manual. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a) and (b)]

10. **Language Assistance Program Standards.** Hospital shall comply with the language assistance standards promulgated by the DMHC and with CalOptima's language assistance program and shall cooperate with CalOptima in providing any information necessary to assess compliance. [HSC § 1367.04(f); 28 CCR § 1300.67.04]

11. **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Hospital will not invoice or balance bill any Member for the difference between the Hospital's billed charges and the reimbursement paid by CalOptima or its capitated provider for any Covered Service. In addition, in the event CalOptima or its capitated provider fails to pay for Covered Services, Members will not be liable to Hospital for any sums owed by CalOptima or its capitated provider. Hospital shall not maintain any action at law against a Member to collect sums owed by CalOptima or its capitated provider. [HSC §§ 1379(a)-(c), 1371.9; 28 CCR § 1300.71(g)(4)]

12. **No Surcharges.** Neither Hospital nor Hospital's agents, trustees, or assignees shall impose or collect a surcharge from a Member for services provided to the Member pursuant to the Contract, nor shall Hospital nor Hospital's agents, trustees, or assignees maintain any action at law against a Member to collect sums owed by CalOptima to Hospital for services provided to the Member pursuant to the Contract. In its agreements with individual providers, Hospital shall (i) prohibit individual providers from imposing or collecting a surcharge from a Member for services provided to the Member

pursuant to the agreement with Hospital and (ii) prohibit the individual provider from maintaining any action at law against a Member to collect sums owed by Hospital to the individual provider for services provided to the Member pursuant to the agreement with Hospital. Upon notice of any such action or upon notice that Hospital or any individual provider has imposed surcharges for Covered Services, CalOptima will take appropriate action. As used in this addendum, the term "**surcharges**" means an additional fee that is charged to a Member for a Covered Service, but that is not approved by the Director of the DMHC ("**Director**"). [HSC § 1379(c); 28 CCR § 1300.67.8(d)]

13. **Reporting or Surcharges and Cost-Sharing.** Hospital will report to CalOptima in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Hospital. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]

14. **Third Party Recoveries.** Hospital shall cooperate with CalOptima in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Hospital from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other Laws.

15. **Claims for Secondary Payment.** CalOptima or its capitated provider will pay Claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. Notwithstanding any other provision in this Contract, if CalOptima or CalOptima's capitated provider is not the primary payer under coordination of benefits, Hospital may submit Claims to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer. Except as otherwise provided by Laws or provided by Government Program Requirements, any Claims that are not submitted by Hospital to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer shall not be eligible for payment, and Hospital hereby waives any right to payment thereof. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]

16. **Good Cause for Late Filing.** If CalOptima or CalOptima's capitated provider denies a Claim because it was filed beyond the Claim filing deadline, CalOptima will, upon Hospital's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

17. **Authorization of CalOptima's Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment CalOptima makes in future payments to Hospital, CalOptima shall furnish Hospital with a separate written notice of the Overpayment that clearly identifies the overpaid amount, Claim, Member's name, Date(s) of Service, and explains the basis for CalOptima's request for reimbursement of the Overpayment, including any interest and penalties on the Claim. If Hospital intends to contest CalOptima's notice, Hospital must send written notice of Hospital's intent to contest within thirty (30) Business Days of Hospital's receipt of CalOptima's notice. If CalOptima does not receive a notice of intent to contest notice of the Overpayment or the requested reimbursement from Hospital within the above timeframes, Hospital authorizes CalOptima to offset or recoup the requested reimbursement amount from CalOptima's payments to Hospital for current or future Claim submissions. [28 CCR § 1300.71(d)]

18. **Hospital Dispute Resolution.** CalOptima shall establish and maintain a provider dispute resolution process to process and resolve any Hospital disputes, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Hospital may obtain specific information regarding CalOptima's provider dispute resolution process in CalOptima's policies. Hospital has a right to access CalOptima's provider dispute resolution process. CalOptima will inform Hospital of any changes to CalOptima's provider dispute resolution procedures. Hospital will receive the rights listed in HSC § 1375.7, as amended, if CalOptima makes any changes to the provider dispute resolution process. Hospital may utilize CalOptima's provider dispute resolution

process or obtain information about the process by writing to Hospital Dispute Resolution Claims at the appropriate address outlined in the Hospital Manual or calling: (714) 246-8600. CalOptima's provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1 *et seq.* See the Hospital Manual for current information regarding CalOptima's provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h)(1) and (2); 28 CCR §§ 1300.71.38, 1300.71(e)]

19. **Member Confidentiality.** Hospital will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the Confidentiality of Medical Information Act ("**CMIA**"), including California Civil Code §§ 56.10, 56.104, and 56.107. Hospital shall prohibit individual providers from disclosing medical information regarding a Member unless such disclosure complies with the requirements of the CMIA. [HSC §§ 1348.5, 1364.5; 28 CCR §§ 1300.51(d) K.2, 1300.67.8(a)]

20. **Maintenance and Access to Records.**

20.1. Hospital will prepare and maintain on a current and accurate basis all records, books, and papers related to this Contract ("**Records**") possessed in any medium. Such Records shall be made available for inspection, including through electronic means, and copying by CalOptima and/or the DMHC, as may be necessary for CalOptima's compliance with the provisions of the Knox-Keene Act and the rules.

20.2. To the extent feasible, all Records shall be located in the State of California and shall not be removed without DMHC's prior consent. If Records are located outside California, Hospital shall make such Records available in California or furnish true and accurate copies of such Records.

20.3. If CalOptima and/or DMHC requests to inspect Records, Hospital shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

20.4. To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format. Records must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

20.5. Hospital shall cooperate with CalOptima with respect to any DMHC examination of the fiscal and administrative affairs of CalOptima or CalOptima's subcontractors.

20.6. Hospital shall maintain on a current and accurate basis and ensure ready availability of Medical Records. Upon CalOptima's request, Hospital shall make available, at reasonable times, Hospital's Records relating to the services provided to Members, to the cost thereof, to payments received by Hospital from Members (or from others on their behalf).

20.7. The obligation under this Section 20 shall survive termination of the Contract for any reason.

[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

21. **Amendments.** The Hospital Manual may be unilaterally amended or modified by CalOptima to maintain consistency or compliance with any Laws, policies, directives, government program requirements, or requirements of an Accreditation Organization upon forty-five (45) Business Days' notice to Hospital unless a shorter timeframe is necessary for compliance. CalOptima may otherwise

materially amend the Hospital Manual only after forty-five (45) Business Days' prior written notice to Hospital. If Hospital does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Hospital. If CalOptima receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Hospital has the right to terminate this Contract prior to the effective date of the amendment or modification. [HSC § 1375.7; 28 CCR § 1300.71(m)]

22. **Compliance with Laws.** CalOptima is subject to Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Contract shall bind the Parties whether or not expressly set forth in this Contract.

23. **Quality and Utilization.** CalOptima will disclose to Hospital CalOptima's quality improvement or UM programs and procedures at least fifteen (15) Business Days prior to Hospital executing this Contract. A change to the quality improvement or UM programs or procedures shall be made pursuant to Section 21. Notwithstanding the foregoing, CalOptima may make a change to the quality improvement or UM programs or procedures at any time if the change is necessary to comply with Laws or any accreditation requirements of a private sector Accreditation Organization. [HSC § 1375.7(b)(3)]

24. **Data Usage.** The provisions of this section will apply only to the extent that Hospital, now or in the future, acts as a "**Service Hospital**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code §§ 1798.100 *et seq.*, 1798.140(v), and the regulations promulgated thereunder). Hospital warrants and represents that all Personal Information (as defined below) shall not be: (i) retained, used, or disclosed by Hospital for any purpose other than for the specific purpose of performing the services specified in the Contract; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Hospital shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Contract or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140(t)(1). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140(o).

25. **Health Care Hospitals' Bill of Rights**. Hospital is entitled to all protections afforded to Hospital under the Health Care Hospitals' Bill of Rights. [HSC § 1375.7]

26. **Telehealth Services**. If Hospital uses telehealth for rendering Covered Services, Hospital shall obtain and document Member consent prior to providing telehealth services, as required under Business and Professions Code § 2290.5. As required by HSC § 1374.14, CalOptima shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately delivered through telehealth services on the same basis and to the same extent that CalOptima is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or behavioral health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. If CalOptima delegates responsibilities under HSC § 1374.141 to a contracted entity, the delegated entity shall comply with this section and HSC § 1374.141, as applicable, including obtaining Member consent for use of telehealth services and complying with the records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]

27. **Liabilities**. CalOptima and Hospital are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Contract is void and unenforceable. Nothing in this section shall preclude a finding of liability on

the part CalOptima or Hospital based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]

28. **Reporting.** Hospital agrees to submit all information or reports required under this Contract or requested by CalOptima or DMHC to comply with Laws in a form acceptable to CalOptima or DMHC, including providing necessary information and reports under HSC § 1367.0061.

ATTACHMENT E
LOBBYING CERTIFICATION FORMS

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

@@Provider Name@@	{{Name_es_:signer1: }}
Name of Contractor	Printed Name of Person Signing for Contractor
	{{_es_:signer1:signature}}
Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }}	{{_es_:signer1:title }}
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

@@Custom Field{Lobby Check Box}@@

CERTIFICATION REGARDING LOBBYING

Approved by OMB

0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: {{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	2. Status of Federal Action: {{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	3. Report Type: initial {{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity: {{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: {{RepEntNm_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDist _es_signer1 }}
6. Federal Department/Agency: {{FedDept_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA _es_signer1 }}
8. Federal Action Number, if known: {{FedDept_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s))	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature Value {{Value_es_:signer1 }}	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}}

Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

{{lobby_es_:checkbox:signer1}}

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

AMENDMENT [XX] TO
THE [PROFESSIONAL/ANCILLARY/HOSPITAL] SERVICES CONTRACT

This Amendment [XX] to the [Professional/Ancillary/Provider] Services Contract ("**Amendment**") is effective as of [date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**"), and [Provider name] ("[**Professional/Provider/Hospital**]"). CalOptima and [Professional/Provider/Hospital] may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and [Professional/Provider/Hospital] entered into the [Professional/Ancillary/Provider] Services Contract, originally effective [date] ("**Contract**"), under which [Professional/Provider/Hospital] has agreed to provide or arrange for the provision of certain Covered Services to Members.

B. CalOptima has implemented a Covered California product, and [Professional/Provider/Hospital] desires to provide Covered Services to Members enrolled in CalOptima's Covered California product.

C. CalOptima and [Professional/Provider/Hospital] desire to amend the Contract to incorporate certain provisions and requirements related to the Covered California product.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete the Recitals to the Contract in their entirety and replace them with the following new Recitals:

RECITALS

A. CalOptima is a County Organized Health System formed pursuant to Welfare and Institutions Code § 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008.

B. CalOptima contracts with the State of California, acting through the Department of Health Care Services ("DHCS"), the U.S. Department of Health and Human Services ("HHS"), acting through the Centers for Medicare & Medicaid Services ("CMS"), and Covered California to arrange and pay for health care services rendered to beneficiaries who are enrolled in CalOptima's OneCare (a dual eligible special needs Medicare Advantage plan), Medi-Cal, Covered California, and PACE programs ("Programs").

C. [Professional/Provider/Hospital] provides the items and services described in this Contract and has all certifications, licenses, and permits necessary to furnish such items and services.

D. CalOptima desires to engage [Professional/Provider/Hospital] to furnish, and [Professional/Provider/Hospital] desires to furnish, certain items and services to Members as described herein. CalOptima and [Professional/Provider/Hospital] desire to enter into this Contract on the terms and conditions set forth herein below.

2. Delete Section [2.14/1.7/1.10], *CalOptima Program*, and replace it with the following new Section [2.14/1.7/1.10]:

[2.14/1.7/1.10] "CalOptima Program(s)" means any of the following programs administered by CalOptima: the Medi-Cal, OneCare, the Multipurpose Senior Services Program ("MSSP"), the Program of All-Inclusive Care for the Elderly ("PACE"), or Covered California. Provider participates in the specific Program(s) identified in Attachment A.

3. Delete Section [2.15/1.8/1.11], *CalOptima Regulators*, and replace it with the following new Section [2.15/1.8/1.11]:

[2.15/1.8/1.11] "Regulators" mean those government agencies that regulate and oversee CalOptima, including the HHS Inspector General, CMS, DHCS, the Department of Justice ("DOJ"), the DOJ Bureau of Medi-Cal Fraud, the California Department of Managed Health Care ("DMHC"), the Comptroller General, Covered California, and any other government agencies that have authority to set standards and oversee the performance of the Parties.

4. Delete Section [2.24/1.15/1.17], *Covered Services*, and replace it with the following new Section [2.24/1.15/1.17]:

1.15 **"**Covered Services" means those Medically Necessary health care items, drugs, and services that a Member is entitled to receive under the Member's Program and are identified in Attachment A. Covered Services must generally be Authorized in accordance with CalOptima's Policies, including its utilization management program, except for Emergency Services.

5. Delete Section [2.33/1.18/1.26], Government Agencies, and replace it with the following new Section [2.33/1.18/1.26]:

[2.33/1.18/1.26] "Government Agencies" means federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, Covered California and their respective agents and contractors, including quality improvement organizations (QIOs).

6. Delete Section 1.1, *Program Participating*, of Attachment A and replace it with the following Section 1.1:

1.1 Program Participating. [Professional/Provider/Hospital**]** will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**PACE**
[Y/N]	**Covered California**

7. Add new Section V, *Covered California*, to Attachment [B/C/B], *Compensation*:

V. **Covered California**.

Back to Agenda Back to Item

For Covered Services provided to Covered California Members, CalOptima shall reimburse [Professional/Provider/Hospital] as follows:

[INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

8. Add to the Contract the new Addendum 5, *Covered California Program Requirements*, attached to this Amendment and incorporated into the Contract by this reference.

9. Add to the Contract the new Addendum 6, *Knox-Keene Act Requirements*, attached to this Amendment and incorporated into the Contract by this reference.

10. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract

11. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

12. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR [PROFESSIONAL/PROVIDER/HOSPITAL]	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ADDENDUM 5
Covered California Program Requirements

1. **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Covered California Program addendum.

   1.1. **Clean Claim** means the same as the definition of "complete claim" set forth in 28 CCR § 1300.71(a)(2).

   1.2. **Covered California** means the independent State government entity responsible for regulating the Health Insurance Marketplace for the State.

   1.3. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("**QHP**") issuer to provide administrative services or health care services to qualified individuals and their dependents.

   1.4. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

   1.5. **Emergency Medical Condition** means the same as the definition of "emergency medical condition" set forth in Health & Safety Code ("**HSC**") § 1317.1.

   1.6. **Emergency Services** means those Covered Services for inpatient and outpatient care services, as specified in HSC § 1317.1(a), furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize a Member's Emergency Medical Condition

   1.7. **Medically Necessary**, and **Medical Necessity** means the reasonable and necessary Covered Services needed to prevent, diagnoses, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

   1.8. **"Provider"**, as used in this addendum, shall mean [Professional/Hospital].

2. **Compliance.** Provider agrees to be bound by all provisions of the Qualified Health Plan Issuer Contract between CalOptima and Covered California ("**QHP Contract**") that are applicable to the services Provider provides to CalOptima and its Members. Provider agrees to comply with all applicable laws, including the federal Patient Protection and Affordable Care Act, (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), known collectively as the Affordable Care Act; the California Patient Protection and Affordable Care Act, Assembly Bill 1602 and Senate Bill 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010); the Americans with Disabilities Act of 1990 (42 USC §§ 12101 *et seq*.); the Anti-Kickback Statute (42 USC § 1320a–7b); the Public Contracts Anti-Kickback Act (41 USC §§ 51 *et seq*.); the Stark Law (42 USC § 1395nn); the Knox- Keene Health Care Service Plan Act of 1975 (HSC §§ 1340 *et seq*.); the Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq*.); all applicable laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code); Public Contract Code Section 10295.3 with regard to benefits for domestic partners; environmental laws, rules, and regulations applicable to its operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30 (commencing with Section 42460 of the Public Resources Code) relating to hazardous and solid waste; and any and all other applicable state and federal laws, rules, and regulations applicable to the operation of Covered California, the QHP Contract, and Provider's provision of services under the Contract. Provider will incorporate

such applicable requirements in Provider's contracts with its Subcontractors, including the provisions under §4.4.1(d) of the QHP Contract. [QHP Contract §§ 1.2(c), 1.3(b), 1.13, 4.4.1(b)-(d)]

3. **Nondiscrimination in Administration of Services and Benefits.** Provider and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557 (42 USC § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d *et seq*.), Title IX of the Education Amendments of 1972 (20 USC §§ 1681 *et seq*.), the Age Discrimination Act of 1975 (42 USC §§ 6101 *et seq*.), Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), or subject to any other applicable laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health product or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xv), 1.10(a)]

4. **Conflict of Interest.** Provider agrees to be free from any conflicts of interest with respect to Covered Services provided under the Contract. Provider and its personnel shall not currently have, and shall not have throughout the term of the Contract, any direct interest that may present a conflict in any manner with the performance of services required under the Contract. Provider represents that it is not aware of any conflict of interest or any basis for potential violations with respect to applicable laws that govern referrals required for the provision of certain Covered Services, including federal and state Anti-Kickback and Anti-Self-Referral laws. [QHP §§ 4.4.1(d)(xvi), 1.11]

5. **Nondiscrimination in Workplace.** Provider and its agents, employees, and Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome, mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), aged forty (40) or over, marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Provider and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Provider and its agents and employees shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 10000 *et seq*.). The applicable regulations of the California Fair Employment and Housing Commission implementing Government Code § 12900, set forth in California Code of Regulations Chapter 5 of Division 4 of Title 2, including 2 CCR §§ 11102 *et seq*., are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]

6. **Privacy and Security Requirements for Personally Identifiable Data.** Provider agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 USC §§ 1320d *et seq*., HITECH, and any current and future regulations promulgated under HIPAA or HITECH, all as amended from time to time and collectively referred to herein as the "**HIPAA Requirements**." Provider agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this section that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(a); 45 CFR § 155.260(b)(2)(v)]

   6.1. Provider shall, and shall require that its Subcontractors, maintain technology policies and procedures acceptable to CalOptima that provide reasonable safeguards to protect Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Provider and its Subcontractors. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(e)]

6.2. Provider shall, and shall require that its Subcontractors, comply with all applicable Exchange Protection of Information policies, in accordance with the terms and conditions set forth in Section 10.2 of the QHP Contract, Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(h), 10.2]

6.3. If Provider will have access to Protected Health Information and/or Personally Identifiable Information that is received from, created, or received by CalOptima on behalf of Covered California or in connection with the QHP Contract, Provider agrees to be bound by the same or more stringent restrictions, terms, and conditions as those that apply to CalOptima pursuant to the QHP Contract with respect to such Protected Health Information and Personally Identifiable Information, provided, however, that any restrictions that are more stringent shall be set forth in the Contract. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(i)]

6.4. Provider shall mitigate to the extent practicable, any harmful effect that is known to Provider of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(f)]

6.5. Provider shall cooperate with Covered California in investigating any Breach and/or successful Security Incident involving Protected Health Information and/or Personally Identifiable Information and in meeting Covered California's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving Protected Health Information and/or Personally Identifiable Information is attributable to Provider, Provider shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and CalOptima. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(e)(iii)]

6.6. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of CalOptima, Provider agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR Part 162. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(iv)]

6.7. Provider shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider or its Subcontractors or agents, including (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) State law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of the Breach and to respond to the Breach; (b) mitigate harm to the affected Individual(s); and (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(vi)]

7. **State Agency Reviews**. Provider agrees that Covered California, the California Department of General Services, State Auditors, other State and federal regulatory agencies, or their designated representatives shall, subject to applicable laws regarding the confidentiality and release of Protected Heath Information of Members, have the right to review and to copy any records and supporting

documentation pertaining to the performance of the QHP Contract. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(xxii), 11.5(c)]

8. **Performance Measurement Standards.** Provider shall comply with all QHP Contract requirements and performance measurement standards, including those related to customer service that are applicable to Covered Services. CalOptima shall provide the performance measurement standards to Provider. CalOptima may impose penalties for failure to comply or otherwise act in accordance with applicable performance standards of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xix), Article 7]

9. **Medical Records.** Except with respect to any longer periods that may be required under applicable laws, Provider will maintain a Medical Record documentation system adequate to fully disclose and document the medical condition of each Member, to the extent applicable to the services, and the extent of Covered Services provided to each Member by Provider. Medical Records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by applicable laws, if an audit, litigation, research, evaluation, claim, or other action involving records has not concluded before the end of the seven (7)-year minimum retention period, Provider shall retain the Medical Records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(i) & (xxii), 11.1]

10. **Claims Data**. Provider shall cooperate with CalOptima's obligations under the QHP Contract to maintain historical Claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from the date that the QHP Contract is terminated with respect to Covered Services provided to Members during the term of the QHP Contract. These records shall include the data elements required to produce specific reports mutually agreed upon by Covered California and CalOptima and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable of CalOptima's Regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductibles, out-of-pocket costs, and other cost-sharing for each Claim. [QHP Contract §§ 4.4.1(d)(xiv) and (xii), 11.2(c)]

11. **Financial Records**. Financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by Provider in connection with the QHP Contract shall be retained by Provider for at least ten (10) years from the date of the final Claims payment, unless a longer maintenance period is required by applicable laws or the QHP Contract. Provider shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to Provider. This shall include: (i) adequate data customarily maintained and reasonably necessary to properly document each of Provider's transactions with CalOptima during the period the QHP Contract remains in force; and (ii) records of Claims, including medical review and high dollar special audit Claims. [QHP Contract §§ 1.12, 4.4.1(d)(xiv), (xxii), 11.2(a), 11.2(b)]

12. **Books and Records Location**. Books and records shall be kept in a secure location at Provider's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by CalOptima, Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10)-year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), 11.3]

13. **Notice.** Provider shall promptly notify CalOptima in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Provider, personnel, or Subcontractors that is threatened or commenced by any governmental authority or other party that a reasonable person might believe could materially affect the ability of CalOptima to perform in accordance with the terms set forth in the QHP Contract. [QHP Contract §§ 4.4.1(d)(xxii), 11.6]

14. **Scope of Licensure**. All Covered Services must be provided by duly licensed, certified, or accredited providers consistent with the scope of their Licenses and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in this Contract and the QHP Contract. [QHP Contract § 4.4.1(a)]

15. **QHP Contract Requirements**. Provider agrees to be bound, and to bind each of its Subcontractors, by all provisions of the QHP Contract that are applicable to the Covered Services that Provider and its Subcontractors provide under the Contract [QHP Contract § 4.4.1(d)], including:

    15.1. Coordination with Covered California and other programs and stakeholders.

    15.2. Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and CalOptima's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].

    15.3. Participating Provider directory requirements [QHP Contract § 4.4.4].

    15.4. Symphony provider directory requirements [QHP Contract § 4.4.5)].

    15.5. Implementation of processes to enhance stability and minimize disruption to the provider network [QHP Contract § 4.3.3].

    15.6. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].

    15.7. Provider credentialing, including maintenance of licensure and insurance [QHP Contract § 3.4.2].

    15.8. Customer service standards [QHP Contract § 4.6].

    15.9. Utilization managements processes [QHP Contract § 5.3].

    15.10. Maintenance of a corporate compliance program [QHP Contract § 1.2].

    15.11. Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].

    15.12. Appeals and grievances [QHP Contract § 4.6.2].

    15.13. Member and marketing materials [QHP Contract § 3.2].

    15.14. Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.12], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].

    15.15. Nondiscrimination [QHP Contract § 1.10].

    15.16. Conflict of interest and integrity [QHP Contract § 1.11].

    15.17. Other applicable laws [QHP Contract § 1.13].

    15.18. Advancing equity, quality, and value to the extent applicable to Participating Providers [QHP Contract Article 5], including disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 1, Advancing Equity, Quality, and Value, to the QHP Contract.

    15.19. Performance measures, to the extent applicable to Participating Providers [QHP Contract

Article 7].

15.20. Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.3 and Article 8].

15.21. Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].

15.22. Maintenance of books and records [QHP Contract Article 11].

16. **Cooperation**. Provider recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, CalOptima, Provider, and any other authorized Subcontractors. Provider shall coordinate and cooperate with CalOptima and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. Provider shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of the California Healthcare Eligibility, Enrollment, and Retention System with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other applicable laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.6]

17. **Subcontractor Selection**. Provider shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any CalOptima approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable laws, rules, regulatory requirements, and orders. Provider's obligations pursuant to this Contract and applicable laws shall not be waived or released if Provider is permitted to subcontract or otherwise delegate services of this Contract. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]

18. **Independent Contractors**. Nothing in the QHP Contract or this Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Provider or CalOptima and Provider. The Parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]

19. **Provider Directory**. Provider shall provide information to CalOptima to allow CalOptima to comply with its provider directory obligations under the QHP Contract. Provider acknowledges that Covered California may use Provider's data for any noncommercial purposes. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

20. **Member Liability**. Provider shall comply with laws governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if CalOptima fails to pay an amount owed by CalOptima to Provider. Provider shall inform every Member in a manner that allows the Member the opportunity to act upon Provider's proposal or recommendation regarding (i) the use of a non-Participating Provider or (ii) the referral of a Member to a non-Participating Provider for proposed non-Emergency Services. Provider shall disclose to a Member considering accessing non-Emergency Services from a Participating Provider if a non-Participating Provider will be used as part of the Participating Provider's plan of care. Provider is responsible for complying with the Provider Manual and may rely upon the provider directory of CalOptima in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]

21. **Credentialing**. If Provider is delegating activities relating to credentialing and re-credentialing, the process used by Provider must be reviewed and approved by CalOptima and as otherwise required by DMHC or any other applicable Regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]

22. **Utilization Management**. Provider shall cooperate and comply with and participate in the UM Program established by CalOptima in compliance with applicable laws, including HSC § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]

23. **Eligibility and Enrollment Determinations**. Provider shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to CalOptima in its efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2, Article 3]

24. **Grievances and Appeals**. Provider shall cooperate and comply with the internal review process established by CalOptima to resolve Member written or oral grievances and appeals, including those involving expressions of dissatisfaction regarding Provider. Provider shall comply with State and federal laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2]

25. **Quality, Network Management, and Delivery System Standards**. Provider shall cooperate and comply with programs established by CalOptima consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to CalOptima to ensure CalOptima's compliance with its required reporting obligations pursuant to Attachment 1, Advancing Equity, Quality, and Value, of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]

26. **Customer Service Standards**. Provider shall comply with all applicable QHP Contract customer service standards that are applicable to Provider. [QHP Contract §§ 4.4.1(d)(viii), 4.6]

27. **Continuity of Care**. Provider agrees to comply with policies and procedures implemented by CalOptima to enhance stability and minimize disruption to CalOptima's provider networks. Provider shall provide CalOptima with the information necessary to comply with notice and other requirements in the cases of block transfers (HSC § 1373.65) and network disruptions (HSC §§ 1373.23 and 1366.1). In the event of a change related to network disruption, block transfers, or other similar circumstances, Provider shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under applicable laws, including those relating to continuity of care set forth at HSC § 1373.95 and as otherwise set forth in the QHP Contract. In the event of termination of the QHP Contract or decertification of one or more of CalOptima's QHPs, Provider shall cooperate fully with CalOptima and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(xx), 4.3.3, Article 8]

28. **Fraud, Waste, and Abuse Programs**. Provider shall maintain compliance and provide CalOptima with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance of its obligations and CalOptima's reporting obligations under the QHP Contract. [QHP Contract §§ 4.4.1(d)(x), 1.2, 1.15]

29. **Insurance**. Provider shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable laws. [QHP Contract § 9.1.3]

30. **No Surprises Act**. Provider shall comply with the rules against surprise billing in the Consolidated Appropriations Act of 2021 (the "**No Surprises Act**"), including complying with applicable cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections. If Provider is responsible for processing Claims for Covered Services rendered by out-of-network providers, Provider shall process such Claims in accordance with the No Surprises Act. [HSC § 1371.9; 45 CFR §§ 149.410, 149.420, 149.430, 149.440]

31. **CalOptima Accountability.** Notwithstanding any relationship CalOptima may have with Provider, as Delegated Entity, and any Downstream Entity, CalOptima maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all

applicable standards enumerated at 45 CFR § 156.340(a). [45 CFR § 156.340(a)]

32. **Delegated Entity and Downstream Entity Compliance.** If any of CalOptima's issuer activities and obligations, in accordance with 45 CFR § 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to the following provisions and Provider further agrees that it will require Downstream Entities to comply with the same standards. [45 CFR § 156.340(b)]

    32.1. **Standards for Downstream and Delegated Entities.** The Contract, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. [45 CFR § 156.340(b)(1)]

    32.2. **Revocation of Delegated Activities.** In the event the HHS or CalOptima determines, in its sole discretion, that Provider or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR § 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or CalOptima, as applicable. [45 CFR § 156.340(b)(2)]

    32.3. **Compliance with Laws.** Provider will perform such activities and obligations in compliance with all applicable laws and regulations relating to the standards specified in 45 CFR §156.340(a). [45 CFR § 156.340(b)(3)]

    32.4. **Right to Audit.** Provider and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the OIG, or their designees, to evaluate through audit, inspection, or other means, Provider's or the Downstream Entity's books, contracts, computers, or other electronic systems, including Medical Records and documentation, relating to CalOptima's obligations in accordance with the standards enumerated at 45 CFR § 156.340(a), as applicable, until ten (10) years from the final date of the Contract period. [45 CFR § 156.340(b)(4)-(5)]

33. **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits CalOptima from entering into a contract with Provider, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict CalOptima from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or Members, or individuals eligible to become participants, beneficiaries, or Members of the plan or coverage; (ii) electronically accessing de-identified Claims and Encounter Data for each participant, beneficiary, or Member; or (iii) sharing such information, consistent with applicable privacy laws. Notwithstanding anything to the contrary in this Contract, Provider agrees that CalOptima is in compliance with this provision with respect to this Contract and nothing in this Contract will prohibit CalOptima from complying with this provision.

ADDENDUM 6
Knox-Keene Act Requirements

1. **Applicability**. This Knox-Keene Act addendum shall apply to the Program(s) governed by the Knox-Keene Act and regulated by the DMHC. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, Medicare, or PACE Programs. As used in this addendum, "**Provider**" shall mean [Professional/Hospital].

2. **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of HSC 1367.03 and 28 CCR § 1300.67.2.2 and in a manner that provides continuity of care, including the availability of primary care providers ("**PCPs**") who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or Provider to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and applicable State laws. Provider shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Provider has any role in rendering Emergency Services, Provider will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Provider shall provide reporting required by CalOptima and DMHC necessary to ensure compliance with DMHC accessibility and network adequacy standards. Provider will comply with CalOptima's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments. [HSC §§ 1367, 1367.03, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]

3. **Licensure and Certification**. As applicable, Provider and its employed and contracted personnel shall be licensed and certified by their respective board or agency, where licensure or certification is required by law to provide services under the Contract. As applicable, any equipment used by Provider and/or its employed and contracted personnel under the Contract required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. [H&S Code § 1367(b)-(c)]

4. **Coordination of Member Care.** Provider is responsible for coordinating the provision of health care services to a Member if Provider is acting as the Member's PCP. Provider shall maintain Member Medical Records in a readily available manner that permits sharing with CalOptima of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]

5. **Provider Directory Information.** Provider shall inform CalOptima within five (5) business days of material changes that would affect Provider's or its Contracted Providers' listing in CalOptima's provider directory, so that CalOptima can comply with HSC § 1367.27. Material changes include:

   5.1. The addition or deletion of a Contracted Provider from Provider's group of providers.

   5.2. A change in Provider's or a Contracted Provider's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.

   5.3. Whether Provider or its Contracted Providers are or are not accepting new patients.

   If Provider or one of its Contracted Providers is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Provider shall direct the Member or potential Member to CalOptima for additional assistance in finding a provider and to DMHC to report any inaccuracy with CalOptima's directories.

   Provider shall provide to CalOptima any information necessary for CalOptima to comply with applicable State laws. If Provider does not comply with this provision or demonstrates a pattern of

repeated failure, CalOptima may terminate the Contract. [HSC § 1367.27]

6. **Notices to Members of Termination or Block Transfer.** Provider shall cooperate and assist CalOptima in fulfilling CalOptima's obligations under 28 CCR § 1300.67.1.3 regarding block transfer filings with the DMHC. Any written communications to Members that concern a termination of this Contract or block transfer shall comply with the notification requirements in HSC § 1373.65(f). CalOptima shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]

7. **Continuation of Care after Termination for Certain Conditions.** If the Contract is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Provider will, at the request of the Member and CalOptima, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Reimbursement for such services will be at the applicable rates listed in Attachment [B/C/B], *Compensation*. Upon termination of the Contract, CalOptima is liable for the Covered Services rendered by Provider (other than any permissible co-payments, co-insurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Provider's care at the time of termination of the Contract until the Covered Services the Provider is rendering to the Member are completed or until CalOptima makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Provider. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]

8. **Quality Assurance Program.** CalOptima will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Provider will assist CalOptima in maintaining CalOptima's quality assurance program, as applicable, and consistent with CalOptima's quality assurance program policies and procedures. To the extent that any of CalOptima's quality assurance functions are delegated to Provider, Provider shall promptly deliver to CalOptima all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions and so that CalOptima may comply with applicable laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2(d), 1300.70]

9. **No Inducement to Deny Covered Services.** Provider acknowledges and agrees that this Contract does ***not*** (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Provider to induce Provider to provide care to Members in a manner inconsistent with coverage requirements. Provider shall ensure that its contracts with individual providers similarly comply with this Section 9. [HSC §§ 1348.6, 1367.62(a)(3)]

10. **Appeals and Grievances of Members.** CalOptima will be responsible for resolving Member appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. CalOptima's process to resolve provider grievances are set forth in the Contract and CalOptima Policies. Provider will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Provider shall assist and cooperate with CalOptima in responding to Member grievances and requests for independent medical reviews consistent with CalOptima Policies, including the Provider Manual. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a) and (b)]

11. **Language Assistance Program Standards.** Provider shall comply with the language assistance standards promulgated by the DMHC and with CalOptima's language assistance program and shall cooperate with CalOptima in providing any information necessary to assess compliance. [HSC §

1367.04(f); 28 CCR § 1300.67.04]

12. **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Provider will not invoice or balance bill any Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima or its capitated provider for any Covered Service. In addition, in the event CalOptima or its capitated provider fails to pay for Covered Services, Members will not be liable to Provider for any sums owed by CalOptima or its capitated provider. Provider shall not maintain any action at law against a Member to collect sums owed by CalOptima or its capitated provider. [HSC §§ 1379(a)-(c), 1371.9; 28 CCR § 1300.71(g)(4)]

13. **No Surcharges.** Neither Provider nor Provider's agents, trustees, or assignees shall impose or collect a surcharge from a Member for services provided to the Member pursuant to the Contract, nor shall Provider nor Provider's agents, trustees, or assignees maintain any action at law against a Member to collect sums owed by CalOptima to Provider for services provided to the Member pursuant to the Contract. In its agreements with individual providers, Provider shall (i) prohibit individual providers from imposing or collecting a surcharge from a Member for services provided to the Member pursuant to the agreement with Provider and (ii) prohibit the individual provider from maintaining any action at law against a Member to collect sums owed by Provider to the individual provider for services provided to the Member pursuant to the agreement with Provider. Upon notice of any such action or upon notice that Provider or any individual provider has imposed surcharges for Covered Services, CalOptima will take appropriate action. As used in this addendum, the term "**surcharges**" means an additional fee that is charged to a Member for a Covered Service, but that is not approved by the Director of the DMHC ("**Director**"). [HSC § 1379(c); 28 CCR § 1300.67.8(d)]

14. **Reporting or Surcharges and Cost-Sharing.** Provider will report to CalOptima in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Provider. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]

15. **Third-Party Recoveries.** Provider shall cooperate with CalOptima in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Provider from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other applicable laws.

16. **Claims for Secondary Payment.** CalOptima or its capitated provider will pay Claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. Notwithstanding any other provision in this Contract, if CalOptima or CalOptima's capitated provider is not the primary payer under coordination of benefits, Provider may submit Claims to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer. Except as otherwise provided by applicable laws or provided by Government Contracts or Regulators' requirements, any Claims that are not submitted by Provider to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment thereof. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]

17. **Good Cause for Late Filing.** If CalOptima or CalOptima's capitated provider denies a Claim because it was filed beyond the Claim filing deadline, CalOptima will, upon Provider's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

18. **Authorization of CalOptima's Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment CalOptima makes in future payments to Provider, CalOptima shall furnish Provider with a separate written notice of the Overpayment that clearly identifies the overpaid amount, Claim, Member's name, date(s) of service, and explains the

basis for CalOptima's request for reimbursement of the Overpayment, including any interest and penalties on the Claim. If Provider intends to contest CalOptima's notice, Provider must send written notice of Provider's intent to contest within thirty (30) business days of Provider's receipt of CalOptima's notice. If CalOptima does not receive a notice of intent to contest notice of the Overpayment or the requested reimbursement from Provider within the above timeframes, Provider authorizes CalOptima to offset or recoup the requested reimbursement amount from CalOptima's payments to Provider for current or future Claim submissions. [28 CCR § 1300.71(d)]

19. **Provider Dispute Resolution.** CalOptima shall establish and maintain a provider dispute resolution process to process and resolve any Provider disputes, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Provider may obtain specific information regarding CalOptima's provider dispute resolution process in CalOptima's policies. Provider has a right to access CalOptima's provider dispute resolution process. CalOptima will inform Provider of any changes to CalOptima's provider dispute resolution procedures. Provider will receive the rights listed in HSC § 1375.7, as amended, if CalOptima makes any changes to the provider dispute resolution process. Provider may utilize CalOptima's provider dispute resolution process or obtain information about the process by writing to Provider Dispute Resolution Claims at the appropriate address outlined in the Provider Manual or calling: (714) 246-8600. CalOptima's provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1 *et seq.* See the Provider Manual for current information regarding CalOptima's provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h)(1) and (2); 28 CCR §§ 1300.71.38, 1300.71(e)]

20. **Member Confidentiality.** Provider will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the Confidentiality of Medical Information Act ("**CMIA**"), including California Civil Code §§ 56.10, 56.104, and 56.107. Provider shall prohibit individual providers from disclosing medical information regarding a Member unless such disclosure complies with the requirements of the CMIA. [HSC §§ 1348.5, 1364.5; 28 CCR §§ 1300.51(d) K.2, 1300.67.8(a)]

21. **Maintenance and Access to Records.**

    21.1. Provider will prepare and maintain on a current and accurate basis all records, books, and papers related to this Contract ("**Records**") possessed in any medium. Such Records shall be made available for inspection, including through electronic means, and copying by CalOptima and/or the DMHC, as may be necessary for CalOptima's compliance with the provisions of the Knox-Keene Act and the rules.

    21.2. To the extent feasible, all Records shall be located in the State of California and shall not be removed without DMHC's prior consent. If Records are located outside California, Provider shall make such Records available in California or furnish true and accurate copies of such Records.

    21.3. If CalOptima and/or DMHC requests to inspect Records, Provider shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

    21.4. To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format. Records must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

21.5. Provider shall cooperate with CalOptima with respect to any DMHC examination of the fiscal and administrative affairs of CalOptima or CalOptima's subcontractors.

21.6. Provider shall maintain on a current and accurate basis and ensure ready availability of Medical Records. Upon CalOptima's request, Provider shall make available, at reasonable times, Provider's Records relating to the services provided to Members, to the cost thereof, to payments received by Provider from Members (or from others on their behalf).

21.7. The obligation under this Section 21 shall survive termination of the Contract for any reason.

[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

22. **Amendments.** The Provider Manual may be unilaterally amended or modified by CalOptima to maintain consistency or compliance with any applicable laws, policies, directives, government program requirements, or requirements of an Accreditation Organization upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. CalOptima may otherwise materially amend the Provider Manual only after forty-five (45) business days' prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Provider. If CalOptima receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Provider has the right to terminate this Contract prior to the effective date of the amendment or modification. [HSC § 1375.7; 28 CCR § 1300.71(m)]

23. **Compliance with Laws.** CalOptima is subject to Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Contract shall bind the Parties whether or not expressly set forth in this Contract.

24. **Quality and Utilization.** CalOptima will disclose to Provider CalOptima's quality improvement or UM programs and procedures at least fifteen (15) business days prior to Provider executing this Contract. A change to the quality improvement or UM programs or procedures shall be made pursuant to Section 22. Notwithstanding the foregoing, CalOptima may make a change to the quality improvement or UM programs or procedures at any time if the change is necessary to comply with applicable laws or any accreditation requirements of a private sector Accreditation Organization. [HSC § 1375.7(b)(3)]

25. **Data Usage.** The provisions of this section will apply only to the extent that Provider, now or in the future, acts as a "**Service Provider**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code §§ 1798.100 *et seq.*, 1798.140(v), and the regulations promulgated thereunder). Provider warrants and represents that all Personal Information (as defined below) shall not be: (i) retained, used, or disclosed by Provider for any purpose other than for the specific purpose of performing the services specified in the Contract; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Provider shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Contract or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140(t)(1). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140(o).

26. **Health Care Providers' Bill of Rights**. Provider is entitled to all protections afforded to Provider under the Health Care Providers' Bill of Rights. [HSC § 1375.7]

27. **Telehealth Services**. If Provider uses telehealth for rendering Covered Services, Provider shall obtain

and document Member consent prior to providing telehealth services, as required under Business and Professions Code § 2290.5. As required by HSC § 1374.14, CalOptima shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately delivered through telehealth services on the same basis and to the same extent that CalOptima is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or behavioral health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. If CalOptima delegates responsibilities under HSC § 1374.141 to a contracted entity, the delegated entity shall comply with this section and HSC § 1374.141, as applicable, including obtaining Member consent for use of telehealth services and complying with the records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]

28. **Liabilities**. CalOptima and Provider are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Contract is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part CalOptima or Provider based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]

29. **Reporting.** Provider agrees to submit all information or reports required under this Contract or requested by CalOptima or DMHC to comply with applicable laws in a form acceptable to CalOptima or DMHC, including providing necessary information and reports under HSC § 1367.0061.

30. **Mental Health Parity Requirements**. As applicable, Provider shall comply with all Laws and CalOptima Policies on the provision of Medically Necessary Treatment of Mental Health and Substance Use Disorder, as defined by HSC § 1374.72(a) ("**MH/SUD Services**"). As applicable, Provider shall adopt and use CalOptima Policies when providing MH/SUD Services or, if Provider establishes its own policies, Provider shall obtain CalOptima's prior written approval and shall ensure Provider's policies comply with applicable requirements of HSC §§ 1374.72 and 1374.721, and 28 CCR § 1300.74.72 and 1300.74.721.

COVERED CALIFORNIA PHYSICIAN GROUP SERVICES CONTRACT

between

ORANGE COUNTY HEALTH AUTHORITY dba CALOPTIMA HEALTH

and

[insert provider name]

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ATTACHMENTS

COVERED CALIFORNIA PHYSICIAN GROUP SERVICES CONTRACT (Shared Risk)

This Covered California Physician Group Services Contract ("**Contract**") is effective [insert effective date] ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**"), and _____, a _____ ("**Physician Group**"). CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System formed pursuant to Welfare and Institutions ("**W&I**") Code § 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008.

B. CalOptima contracts with the California Health Benefit Exchange ("**Covered California**"), to arrange and pay for the provision of services to Covered California beneficiaries residing in Orange County, California, and assigned to CalOptima to receive Covered Services.

C. Physician Group is a duly licensed California professional medical corporation that employs or otherwise contracts with physicians who are licensed to practice medicine in the State and other Providers who are appropriately licensed in the State.

D. CalOptima and Physician Group desire to enter into this Contract whereby Physician Group will perform delegated administrative services and furnish health care items and services as described herein to certain Members enrolled in CalOptima's Covered California Program on the terms and condition(s) set forth herein.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

1.1 "**Accreditation Organization**" means any organization engaged in accrediting, certifying, and/or approving CalOptima, Hospital, and/or their respective programs, centers, or services, including the National Committee for Quality Assurance ("**NCQA**") and The Joint Commission.

1.2 "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Physician Group, as set forth under the Contract and in CalOptima Policies.

1.3 "**Advance Directive**" means a written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make their health care wishes known.

1.4 "**AMSC**" means the alcohol misuse screening and counseling services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

1.5 "**APLs**" and "**Policy Letters**" are means by which Covered California and/or DMHC conveys information or interpretation of changes in policy or procedure at the federal or State levels. APLs (also known as all plan letters) and Policy Letters provide instruction about changes in Laws and how services are delivered to Members.

1.6 "**Appeals**" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

1.7 "**Authorization**", "**Authorize**", or "**Authorized**" means the written or telephonic approval of CalOptima or its delegate (which may include Physician Group) for the provision or referral of Covered Services, other than Emergency Services, in accordance with CalOptima Policies, Laws, and this Contract.

1.8 "**Basic PHM**" means basic population health management, which is an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and NCQA standards.

1.9 "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Members by a separate mental health plan, CalOptima, or their subcontractors.

1.10 "**Business Day**" means Monday through Friday, except for legal holidays under State law, which are identified on the California Department of Human Resources' State Holidays website. References in this Contract are to calendar days unless specifically noted that the time frame is in Business Days.

1.11 "**CalOptima Policies**" means the policies and procedures relevant to this Contract, including those set forth in CalOptima's Provider Manual, provider newsletters, or other written communications to providers, and as amended from time to time at the sole discretion of CalOptima. CalOptima Policies include network management, quality management and improvement, utilization review, credentialing, peer review, Claims billing and reimbursement, member rights and responsibilities, and grievances and appeals, and Physician Group's failure to comply with CalOptima Policies constitutes a breach of this Contract.

1.12 "**Capitation Payment**" means the monthly payment to Physician Group by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician Group's monthly enrollment.

1.13 "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to Members.

1.14 "**Care Management Services**" means:

1.14.1 Providing or approving all Covered Services, including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultations, referrals for consultation, and additional health care services;

1.14.2 Coordinating Covered Services with other health care benefits not covered under this Contract;

1.14.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.14.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.14.5 Authorization of referred services;

1.14.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs;

1.14.7 Coordinating care for Members transitioning from COD to a Health Network or from one Health Network to another Health Network; and

1.15 "**CCR**" means the California Code of Regulations.

1.16 "**CFR**" means the Code of Federal Regulations.

1.17 "**Claim**" means a request for payment submitted by a provider for services provided to a Member.

1.18 "**Clean Claim**" means a "Complete Claim" under Laws, including 28 CCR § 1300.71(a)(2) that also complies with the terms of this Contract and CalOptima Policies.

1.19 "**CMS**" means the Centers for Medicare and Medicaid Services.

1.20 "**Complex Case Management**" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. Physician Group shall provide Complex Case Management services in collaboration with the Member's PCP, and include, at a minimum:

1.20.1 The same services covered by Basic PHM;

1.20.2 Management of acute and/or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;

1.20.3 Intense coordination of resources to ensure the Member regains optimal health or improved functionality; and

1.20.4 With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

Complex Case Management will comply with applicable NCQA standards for complex case management.

1.21 "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with Laws and ethical standards. The Compliance Program includes CalOptima's fraud, waste, and abuse ("**FWA**") plan.

1.22 "**Community Network**" means CalOptima's direct health network that serves Members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to

primary care providers ("**PCPs**") as their medical home, and their care is coordinated through the PCP.

1.23 "**Concentration Languages**" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.24 "**Contracted Provider**" means a Provider that is contracted with Physician Group to provide Covered Services to Members. All Contracted Providers are considered Subcontractors.

1.25 "**County**" means the County of Orange, State of California.

1.26 "**Covered California Contract**" means the written agreement between CalOptima and Covered California pursuant to which CalOptima arranges and pays for the provision of Covered Services to certain Covered California beneficiaries in the County.

1.27 "**Covered Services**" means those Medically Necessary items, services, and drugs that a Member is entitled to receive pursuant to the Covered California Program. Covered Services must generally be Authorized in accordance with CalOptima Policies, including its utilization management program, except for Emergency Services.

1.28 "**DMHC**" means the California Department of Managed Health Care.

1.29 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1.29.1 Placing the Member's health (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

1.29.2 Serious impairment to bodily functions; or

1.29.3 Serious dysfunction of any bodily organ or part.

1.30 "**Emergency Services**" has the same meaning as defined in Health & Safety Code § 1317.1(a).

1.31 "**Encounter Data**" means the record of a Member receiving any items(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. Encounter Data records shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by Regulators.

1.32 "**Facility**" means any premises:

1.32.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.32.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.33 "**Family Planning**" means Covered Services that are provided to Members of childbearing age to enable them to determine the number and spacing of their children and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes:

1.33.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.33.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.33.3 Patient visits for the purpose of Family Planning;

1.33.4 Family Planning counseling services provided during a regular patient visit;

1.33.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.33.6 Tubal ligations;

1.33.7 Vasectomies;

1.33.8 Contraceptive drugs or devices; and

1.33.9 Treatment for complications resulting from previous Family Planning procedures.

Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.34 "**FQHC**" means a federally qualified health center, as defined in 42 USC § 1396d(l)(2)(B).

1.35 "**FFS**" means the fee-for-service reimbursement paid to Providers on a non-capitated basis.

1.36 **"Government Contract(s)"** means the contract(s) between CalOptima and the federal and/or State government, including the Covered California Contract, pursuant to which CalOptima administers and pays for Covered Services under a Program.

1.37 "**Health Education**" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.38 "**Health Network**" means a PHC, physician group under a shared risk contract, or health care service plan licensed under the Knox-Keene Act that contracts with CalOptima on a capitated basis to provide Covered Services to Members.

1.39 "**HHS**" means the United States Department of Health and Human Services.

1.40 "**Hospital**" means a general acute care hospital (i) licensed under the laws of the State and accredited by The Joint Commission, or other CMS deemed accrediting body, (ii) certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the SSA), (iii) that is contracted with CalOptima.

1.41 "**ICP**" is an individual care plan developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of their disease process, and lifestyle choices.

1.42 "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including Regulators' operational guidance and other instructions related to the coverage, payment, and/or administration of Programs, including DMHC and Covered California APLs and Policy Letters.

1.43 "**Licenses**" means all licenses, certifications, accreditations, approvals, and permits that a Provider, including Physician Group, must have in order to participate in the Programs and furnish the items and/or services under this Contract.

1.44 "**Medically Necessary**" or "**Medical Necessity**" means the reasonable and necessary Covered Services needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

1.45 "**Medical Record(s)**" means any record kept or required to be kept by any Provider that documents medical services received by the Member, including inpatient, outpatient, emergency care, referral requests, and Authorizations, as required by Laws and CalOptima Policies.

1.46 "**Medical Supplies**" means items that, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician-ordered plan of care, excluding common household items and clothing.

1.47 "**Medicare**" means the federal health insurance program defined in Title XVIII of the SSA and the regulations promulgated thereunder.

1.48 "**Member**" means a Covered California eligible beneficiary who is enrolled in a Program and assigned to Physician Group.

1.49 "**Minimum Standards**" means the minimum participation criteria established by CalOptima that Providers and Health Networks must satisfy to receive reimbursement from CalOptima for items and/or services furnished to Members, as further described in CalOptima Policies.

1.50 "**MTP**" means a special medical therapy program within the CCS Program that provides physical, occupational, and therapy conference services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.51 "**Non-Participating Provider**" means a Provider that is not contracted with either CalOptima or Physician Group to provide Covered Services to Members.

1.52 "**Outpatient Mental Health Services**" means outpatient services provided to Members with mild-to-moderate mental health conditions, including (i) individual or group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate mental health condition; (iii) psychiatric consultation for medication management; and (iv) outpatient laboratory, supplies, and supplements.

1.53 "**Overpayment**" means a payment Physician Group receives that, after applicable reconciliation, Physician Group is not entitled to receive or retain pursuant to Laws, Government Contracts, and/or this Contract.

1.54 "**Participating Provider**" means an institutional, professional, or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.55 "**Participation Status**" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in federal and/or state health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.56 "**PCP**" means a Contracted Provider primary care physician responsible for (i) supervising, coordinating, and providing initial and primary care to Members, (ii) serving as the medical home for Members; and (iii) for maintaining the continuity of patient care. The PCP is a general Practitioner, internist, pediatrician, family Practitioner, or obstetrician/gynecologist ("**OB/GYN**").

1.57 "**Person-Centered Planning**" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of Basic PHM and Complex Case Management and discharge planning.

1.58 "**PHC**" means a physician-hospital consortium/consortia.

1.59 "**PHI**" means protected health information, as defined under 45 CFR § 160.103.

1.60 "**Practitioner**" means a licensed practitioner, including a doctor of medicine (MD), doctor of osteopathy (DO), doctor of podiatric medicine, doctor of chiropractic medicine (DC), and a doctor of dental surgery (DDS), furnishing Covered Services, as further described in CalOptima Policies.

1.61 "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage ("**MA**") items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.62 "**Privacy Requirements**" means the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, and the California Confidentiality of Medical Information Act ("**CMIA**"), as amended, the implementing regulations of those laws, and any other applicable State of federal laws that protect the privacy or security of personal information disclosed or accessed under this Contract.

1.63 "**Program**" means the Covered California program administered by CalOptima.

1.64 "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

1.65 "**Regulators**" means those government agencies that regulate and oversee CalOptima and Physician Group, including CMS, Covered California, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice ("**DOJ**"), the DMHC, and any other government agencies, or their duly authorized representatives, that have authority to set standards and oversee the performance of the Parties.

1.66 "**Reinsurance**" means coverage provided by CalOptima and any coverage secured by Physician Group that limits the amount of risk or liability for the cost of providing Covered Services.

1.67 "**Shared Risk Pool**" means the risk-sharing program, described in Attachment C-2 hereto, under which the risk for the provision of Covered Services to Members is shared and allocated between CalOptima and Physician Group.

1.68 "**SOC**" means the share of cost the Member owes as part of receiving Covered Services, including co-payments, and deductibles.

1.69 "**Specialist**" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.70 "**Specialized Durable Medical Equipment**" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.71 "**Stabilize(d)**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.72 "**State**" means the State of California.

1.73 "**Subcontract**" means a contract between Physician Group (or its Subcontractor) and a Subcontractor that agrees to provide services related to fulfilling Physician Group's obligations under this Contract.

1.74 "**Subcontractor**" means any Provider, entity, or person that entered into a Subcontract with Physician Group (or another Subcontractor) related to fulfilling any of Physician Group's obligations under this Contract, including Contracted Providers.

1.75 "**Urgent Care Services**" means Covered Services that are not Emergency Services but are required to prevent serious deterioration of a Member's health following the onset of an unforeseen condition or injury for which treatment cannot be delayed, as specifically defined by the rules and regulations governing the applicable Program.

ARTICLE 2
OBLIGATIONS OF PHYSICIAN GROUP

2.1. **Covered Services**. Physician Group shall coordinate Covered Services to Members in accordance with all provisions of this Contract and CalOptima Policies in the same manner and in accordance with the same standards as those services are provided to other patients of Physician Group, including the same availability and access. Physician Group shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all Medically Necessary care and services without regard to the party financially responsible for such care and services and shall refer CalOptima members to Providers that have Hospital privileges at Participating Provider facilities, whenever possible. Physician Group shall provide Covered Services to Members as follows:

2.1.1 Physician Group shall arrange and pay for, consistent with the terms of this Contract and CalOptima Policies, all Covered Services to Members that are the financial responsibility of Physician Group under Attachment A;

2.1.2 If Physician Group's network cannot provide Covered Services under this Contract to a particular Member, Physician Group must adequately and timely cover these services by (i) first referring the Member to a Participating Provider or (ii) if a Participating Provider cannot provide the Covered Services, Physician Group will refer the Member out of network for Covered Services for as long as Physician Group is unable to provide them. Physician Group shall make prior arrangements with Non-Participating Providers for the provision of such services, be fully responsible for arranging and paying for such services, and comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers;

2.1.3 Physician Group shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

2.1.4 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating with Physician Group as to the Medical Necessity of the service, except that each Practitioner shall provide assessment and evaluation services ordered by a court or legal mandate;

2.1.5 Physician Group shall make Covered Services available and accessible to Members promptly and in a manner which ensures continuity of care and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients;

2.1.6 Physician Group shall notify Members when the Physician Group denies, modifies, or defers a PCP's request for Authorization or terminates a previously Authorized service, in accordance with Laws;

2.1.7 Physician Group decisions whether to provide or issue Authorization for Covered Services shall be based solely on Medical Necessity. Physician Group acknowledges that Members can appeal Medical Necessity disputes pursuant to CalOptima Policies and Laws;

2.1.8 Physician Group may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician Group may place appropriate limits on a service on the basis of criteria such as Medical Necessity or utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

2.1.9 Throughout the Term, Physician Group shall maintain the quantity and quality of its (and its Contracted Providers) services and personnel in accordance with the requirements of this Contract, Laws, Government Contracts, Program requirements, and CalOptima Policies; and

2.1.10 Neither Physician Group nor its Subcontractors will perform any work related to the Contract outside the United States of America without the prior written consent of CalOptima, which it may withhold in its sole discretion.

2.2. **Licensure**.

2.2.1 Physician Group represents and warrants that it has, and shall maintain during the Term, all valid and active Licenses necessary to render or arrange for the provision of Covered Services, including (i) certification under and enrollment in Medicaid and Medicare, (ii) all Provider and/or supplier numbers necessary to perform its obligations under this Contract, including National Provider Identifiers ("**NPIs**"), and (iii) being in good standing with State licensing boards applicable to its business, Covered California, DMHC, CMS, and the HHS Officer of Inspector General ("**OIG**"), as applicable.

2.2.2 Physician Group shall ensure that every Provider providing Covered Services and employed or engaged by Physician Group or Subcontractors shall retain at all times during the Term all valid licenses, certifications, and qualifications, without restriction, necessary to provide or arrange for the provision of Covered Services to Members.

2.2.3 Physician Group or its delegate shall additionally verify the qualifications of all employees and Subcontractors providing services under this Contract consistent with the services to be provided. For employees and Subcontractors who have face-to-face contact with Members, Physician Group or its delegate shall also conduct background investigations, including county, state, and federal criminal history and abuse registry screening. Physician Group and its delegates shall comply with all Laws in conducting background investigations and shall exclude unqualified employees and Subcontractors from providing services under this Contract.

2.2.4 Physician Group's facilities, equipment, technology (hardware and software), and administrative services shall be at a level and quality necessary to meet industry standards and perform Physician Group's duties under this Contract and shall comply with Laws.

2.2.5 Physician Group shall notify CalOptima in writing and provide all correspondence with and notices from any government agencies or Accreditation Organizations regarding (i) investigations into Physician Group or its Subcontractors, (ii) citations and/or disapprovals of Physician Group for a failure to meet any material Law or Accreditation Organization standard, or (iii) the issuance of criminal, civil, and/or administrative sanctions (threatened or imposed) related to Physician Group's or a Subcontractor's licensure (including a malpractice lawsuit, FWA, execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status (including any indictment, arrest, or conviction for a felony or for any criminal charge related to Physician Group's services).

2.3 **Compliance With Laws and Policies**. Physician Group shall comply with all Laws in effect during the Term that in any manner affect Physician Group's performance under this Contract. This Contract shall be governed by and construed in accordance with Laws and with the terms and obligations under the Covered California Contract and DMHC requirements. Physician Group understands and agrees that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Physician Group and any Subcontractor are subject to and shall comply with certain laws that are applicable to individuals and entities receiving federal funds, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Americans with Disabilities Act ("**ADA**"). Physician Group also shall comply with all applicable CalOptima Policies. Physician Group agrees to include the requirements of this section in its Subcontracts.

2.4 **Emergency Services**. Physician Group shall comply with all Laws governing the provision and payment of Emergency Services, as well as the applicable requirements of the Covered California Contract, the DMHC, and CalOptima Policies.

2.4.1 Physician Group shall provide and pay for all Emergency Services, including Emergency Services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week.

2.4.2 Physician Group shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior Authorization and in accordance with CalOptima Policies. Physician Group may only deny payment if Physician Group reasonably determines that Emergency Services were never performed.

2.4.3 Physician Group shall reimburse those Providers providing Emergency Services with whom Physician Group has a contract according to the terms of that contract. Physician Group shall offer to contract with any Provider contracting with CalOptima for the provision of Emergency Services on the same terms, conditions and rates as provided for in that CalOptima contract. Physician Group shall reimburse all other Non-Participating Providers providing Emergency Services in accordance with Laws and CalOptima Policies.

2.4.4 Physician Group shall not retroactively deny a Claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition at the time, turned out to be non-emergent.

2.4.5 Physician Group shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition. Further, Physician Group shall not deny payment for treatment obtained when Physician Group or a Contracted Provider instructs a Member to seek Emergency Services.

2.4.6 If there is a disagreement between Physician Group or any Contracted Provider and the treating Non-Participating Provider regarding the Medical Necessity of Covered Services in an emergency, the judgment of the attending physician(s) caring for the Member at the treating facility shall prevail. Physician Group may establish relationships with treating facilities whereby Physician Group may (i) send a Contracted Provider with privileges to assume the attending physician's responsibilities to establish treatment, or (ii) arrange to have a Contracted Provider agree to accept the transfer of the Member after the Member has Stabilized. The attending physician or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge, and that determination is binding on Physician Group.

2.5 **Post-Stabilization Services**.

2.5.1 Physician Group must cover and pay for post-stabilization services in accordance with the Covered California Contract, CalOptima Policies, and Laws, including Health & Safety Code §§ 1262.8, 1371.4 and 28 CCR § 1300.71.4.

2.5.2 Physician Group is financially responsible for post-stabilization services obtained within or outside Physician Group's network that are pre-approved by a Physician Group representative or deemed approved under Laws, including if Physician Group does not

respond to a request for pre-approval within thirty (30) minutes or until Physician Group effectuates the Member's transfer to a Contracted Provider.

2.5.3 Physician Group is financially responsible for payment for post-stabilization services following an admission through the emergency department. Physician Group shall reimburse those Providers providing post-stabilization services with whom Physician Group has a contract according to the terms of that contract. Physician Group shall reimburse all Non-Participating Providers providing post-stabilization services in accordance with Laws and CalOptima Policies.

2.6 **Case Management Services**. Physician Group shall offer a comprehensive Case Management Services program, including Basic PHM and Complex Case Management Services, that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Agreement in Attachment B. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

2.6.1 Physician Group shall develop and implement policies and procedures that outline processes to support Case Management Services, including:

2.6.1.1 Pro-active identification mechanisms of high-risk Members;

2.6.1.2 Referral processes;

2.6.1.3 Triage mechanisms with appropriate time frames;

2.6.1.4 Comprehensive assessment processes and formats;

2.6.1.5 Care plan development and care plan implementation guidelines and format;

2.6.1.6 Carve-out service coordination;

2.6.1.7 Documentation and communications processes for all Case Management Services; and

2.6.1.8 Mechanism for evaluation of Case Management Services program outcomes.

2.6.2 Physician Group's Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

2.6.2.1 Are medically complex, demonstrate an inability to manage their medical condition, and are at risk of exacerbation without intervention;

2.6.2.2 Demonstrate high recidivism;

2.6.2.3 Are chronically ill;

2.6.2.4 Have a catastrophic diagnosis;

2.6.2.5 Have inadequate family/community support;

2.6.2.6 Are cost and/or length of stay outliers;

2.6.2.7 Are receiving six (6) or more chronic medications per month; and

2.6.2.8 Are transitioning between Providers that may cause continuity of care, concerns.

2.6.3 CalOptima may periodically review Physician Group's Case Management Services program to determine compliance with Case Management Services standards. Physician Group shall furnish Case Management Services records and information to CalOptima upon request.

2.6.4 Physician Group's Case Management Services program shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

2.6.5 As a component of the Case Management Services requirements in this Contract, Physician Group shall assure that Physician Group possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines in CalOptima Policies.

2.7 **Newborn Services**. Physician Group shall provide all Covered Services to any newborn child born to a Member as provided under Laws and Covered California requirements.

2.8 **Family Planning**.

2.8.1 Physician Group shall not require prior authorization for Family Planning services.

2.8.2 Physician Group shall ensure that Members have access to Family Planning services through any available Family Planning Provider regardless of whether the provider is a Contracted Provider or a Non-Participating Provider. Physician Group shall provide Family Planning services in a manner that ensures Members have the freedom to choose their preferred method of Family Planning.

2.8.3 Physician Group shall provide information that clearly explains the rights of Members regarding the choice of Family Planning Providers. Physician Group shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to ensure the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

2.8.4 Physician Group shall incorporate specifications of this Section 2.8 in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

2.9 **Moral Objections**. Unless prohibited by Laws, Physician Group shall arrange for the timely referral and coordination of Covered Services to which Physician Group or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate, and ensure provision of services through referrals. Physician Group shall pay for all Covered Services it is financially responsible for under Attachment A, regardless of moral objection.

2.10 **Alcohol and Substance Use Disorder Treatment Services**. Physician Group shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use,

abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC.

2.11 **Advance Directives**. Physician Group shall maintain written policies and procedures related to Advanced Directives and ensure documentation of patient records with respect to the existence of an Advance Directive in compliance with Laws. Physician Group shall not discriminate against any Member based on that Member's Advance Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.12 **Second Opinions**. Physician Group shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions, as required by Laws and CalOptima Policies.

2.13 **Disease Management**. Physician Group shall assist CalOptima in implementation of a Disease Management program in accordance with the delineation of responsibilities in the Delegation Agreement in Attachment B. For purposes of this section, "**Disease Management**" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions that (i) supports the physician/patient relationship; (ii) emphasizes prevention of exacerbation and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management; and (iii) continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

2.14 **Member Visits**. Physician Group shall ensure that Subcontractor facilities licensed pursuant to Health and Safety Code § 1250 permit a Member, at Member's choice, to be visited by a Member's domestic partner, the children of a Member's domestic partner, and/or the domestic partner of the Member's parent or children. Physician Group shall include the requirement of this section in its Subcontracts with such health facilities.

2.15 **Research**. Physician Group agrees to participate in and make data available for research projects initiated or approved by CalOptima.

ARTICLE 3
ACCESS TO COVERED SERVICES

3.1. **Physician Coverage**. Physician Group shall ensure that a physician Contracted Provider or physician employed by Physician Group is available twenty-four (24) hours a day, seven (7) days a week for timely Authorization and consultation for Covered Services, including authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in a Non-Participating Provider emergency department, and for general communication with emergency department personnel, if necessary, in accordance with Laws and CalOptima Policies. In addition, Physician Group shall ensure disputed requests for Authorizations are timely resolved in accordance with Laws and CalOptima Policies

3.2. **Urgent Care**. Physician Group shall make Covered Services available in accordance with Section 3.5.3 of the Contract, the Covered California Contract, and Laws.

3.3. **Initial Health Assessment Appointment**. Physician Group shall have a process to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) days following assignment of a Member by CalOptima, unless otherwise directed by CalOptima. At a

minimum, an initial health assessment shall include a medical history, weight and height data, blood pressure, preventive health screens and tests required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment, and development of care plans, as appropriate. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under eighteen (18). CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician Group's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician Group shall ensure that health assessment information is recorded in the Member's Medical Record.

3.4. **Appointments for Pediatric Preventive Services**. Physician Group shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics ("**AAP**") periodic schedule. Immunizations must be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices ("**ACIP**"). If there are any conflicts in the guidelines, Physician Group shall use the higher standard. Adult Members shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

3.5. **Days to Appointments**.

3.5.1 Non-Emergency Services. Physician Group shall ensure that appointments are scheduled with a PCP for Covered Services that are not Emergency Services or Urgent Care Services within ten (10) Business Days of a Member's request. Physician Group shall also have a process in place for follow-up on Member missed appointments.

3.5.2 Specialist Services. Physician Group shall ensure that appointments are scheduled with Specialists within fifteen (15) Business Days of request of appointment. Physician Group shall arrange for the provision of Medically Necessary Covered Services from Specialists outside its Provider network if those Specialist services are not timely available within Physician Group's network.

3.5.3 Access to Other Services. Members shall be offered appointments within the following timeframes:

3.5.3.1 Urgent care appointment for services that do not require prior authorization – within forty-eight (48) hours of a request;

3.5.3.2 Urgent care appointment for services that do require prior authorization – within ninety-six (96) hours of a request;

3.5.3.3 Non-urgent primary care appointments – within ten (10) Business Days of a request;

3.5.3.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) Business Days of request; and

3.5.3.5 Non-urgent appointment with a non-physician mental health provider – within ten (10) Business Days of request.

3.5.4 Preventive Services. Physician Group shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice, as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

3.5.5 Maternity Covered Services. Physician Group shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable DMHC regulations governing timely access to non-emergency health care services. Physician Group shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services.

3.5.6 Extended Time for Appointments. The applicable waiting time for a particular appointment may be extended if the referring or treating Provider or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's Medical Record that a longer waiting time will not have a detrimental impact on the health of the Member. Physician Group must make the Medical Record available to DMHC upon request and ensure that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a grievance disputing the extension.

3.6 **Office Waiting Times**. Physician Group shall measure office waiting times to ensure compliance with DMHC and Covered California access and availability requirements and CalOptima Policies by its Contracted Providers and shall take appropriate action to provide notice to Contracted Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician Group's failure to monitor and enforce Contracted Provider office wait time requirements in accordance with the terms of this Contract may subject Physician Group to sanctions as set forth in this Contract and CalOptima Policies.

3.7 **Referral Decision Time Limits**. Physician Group shall provide a decision on Authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialist referrals, as set forth in CalOptima Policies, including its utilization management program, and Laws. These Covered Services shall be provided or made available to the Member in accordance with Laws. Physician Group shall take no punitive action of any kind and shall ensure that no Subcontractor takes any punitive action of any kind, against a Contracted Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.8 **Provider-to-Member Staffing Ratios**.

3.8.1 Provider-to-Member Ratios. As specified by State Laws, Physician Group shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

3.8.1.1 PCPs 1:2,000 Members;

3.8.1.2 Total physicians 1:1,200 Members; and

3.8.1.3 If non-physician Practitioners are included in Physician Group's Provider network, each individual non-physician Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

3.8.2 Supervising Physicians. Physician Group shall ensure that its employed or contracted physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisors to non-physician medical practitioners shall satisfy the requirement of a minimum of one (1) physician to:

3.8.2.1 Four (4) nurse practitioners;

3.8.2.2 Four (4) physician assistants; or

3.8.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

3.9 **Provider Geographic Distribution.**

3.9.1 **PCP Geographic Distribution**. Physician Group SHALL make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

3.9.2 **Specialist Geographic Distribution**. Physician Group shall make available to every Member Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence, as required in W&I Code § 14197(b)-(c). Physician Group shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence.

3.9.3 **Hospital Geographic Distribution**. Physician Group agrees that each Hospital that is a Contracted Provider shall be located within ten (10) miles or thirty (30) minutes of the PCP's designated service area with active medical staff privileges at that Hospital.

3.10 **Changes in Availability or Location of Covered Services**. Any substantial change in the availability or location of services provided under this Contract shall require CalOptima's prior written approval. Physician Group's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. The DMHC's denial of the proposal shall prohibit implementation of the proposed changes. Physician Group's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 3.11 of this Contract.

3.11 **Notices About PCP Changes**. Physician Group shall give Members prior written notice if their PCP withdraws from Physician Group's network. Unless otherwise directed by the DMHC or required by Laws, Physician Group shall issue notice as follows: (i) at least thirty (30) days prior to the effective date of a PCP's withdrawal or termination from Physician Group or (ii) at least fifteen (15) days after receipt of notice from a PCP of their intent to withdraw or terminate from Physician Group, whichever is longer. All Member notices shall be submitted to CalOptima for

prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician Group. With the exception of PCP terminations in which a PCP is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, Members not receiving thirty (30) days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician Group's Provider network for up to sixty (60) days or until Member chooses a new PCP.

3.12 **Choice of PCP**. Physician Group shall offer each Member the opportunity to choose a PCP affiliated with the Physician Group. A Member may elect to obtain primary care services from a contracted non-physician Practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician Group receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician Group shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) days of notification of a Member's enrollment with Physician Group. Physician Group shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

3.13 **Provider Eligibility**. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any federal and/or State health care programs; (ii) not ever have been suspended, excluded, or otherwise ineligible to participate in any federal and/or State health care programs based on a mandatory exclusion, as defined in 42 U.S.C. § 1396a-7(a); (iii) have not been convicted of any felony or any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse; and (iv) not have been found liable for fraud or abuse in any civil proceeding or entered into a settlement in lieu of conviction for fraud or abuse in any government program within the previous ten (10) years.

3.14 **Physical Access**. Physician Group and its Subcontractors' facilities shall comply with Laws, including the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, including ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.15 **Provider Directory Accuracy**.

3.15.1 Physician Group shall provide demographic and other information about its Contracted Providers, employed individual providers, and facilities, as applicable and requested by CalOptima, including (i) specialties (ii) certifications; (iii) panel availability, (iv) addition of new providers; (v) mailing addresses; (vi) billing addresses; (vii) phone numbers; (viii) fax numbers; and (ix) office hours and shall promptly notify CalOptima of changes to such information during the Term.

3.15.2 CalOptima may list the name, address, and telephone number of Physician Group, each Contracted Provider, and a description of Provider's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster.

3.15.3 Physician Group shall notify CalOptima within five (5) Business Days when (i) a Contracted Provider is not accepting new Members, or (ii) if the Contracted Provider had previously not accepted new Members, the Contracted Provider is currently accepting new Members.

3.16 **Out-Of-County Services**. Physician Group may contract with out-of-County facilities for Covered Services for Members, provided that Physician Group ensures that it coordinates the Member's care and complies with all access, quality, and other requirements in Covered California Contract, Laws, and CalOptima Policies.

ARTICLE 4
QUALITY OF CARE OBLIGATIONS OF PHYSICIAN GROUP

4.1 **Health Education and Prevention**. Physician Group shall inform Members of contributions Members can make to the maintenance of their health and the proper use of health care services, and Physician Group shall have a program of health education and prevention ("**HEP**") available in accordance with the delineation of responsibilities in Attachment B. Physician Group shall:

4.1.1 Coordinate and integrate with CalOptima's Quality Improvement and Health Equity Transformation Program ("**QIHETP**");

4.1.2 Refer Members to appropriate HEP, based on the Member's needs;

4.1.3 Implement and utilize the Staying Healthy Assessment Tool, as defined in CalOptima Policies; and

4.1.4 Educate Providers and Members regarding HEP services available to Members.

4.2 **Quality Improvement and Health Equity Program**. Physician Group shall participate and cooperate in CalOptima's QIHETP. Physician Group shall establish, maintain and operate a quality improvement ("**QI**") program, in accordance with the delineation of responsibilities in Attachment B, which shall include an annual program plan, work plan, and annual evaluation of effectiveness of the QI program, which are consistent with CMS, Accreditation Organization, Covered California, and DMHC requirements, as well as current industry standards and the requirements of CalOptima's QIHETP program. Physician Group shall facilitate quality studies and assist in collection of comparative data collected from all Contracted Providers using objective parameters (*e.g.*, the current version of Healthcare Effectiveness Data and Information Set (HEDIS) standardized performance measures sponsored and maintained by NCQA). Physician Group shall submit reports related to QI, as required by CalOptima Policies or otherwise required by the DMHC.

4.2.1 Physician Group shall adopt a detailed written QI Plan, which shall include:

4.2.1.1 Well defined goals and objectives of the QI program;

4.2.1.2 A well-defined scope of the QI program that considers all different types and levels of care and service provided to Members; and

4.2.1.3 Clearly defined accountability and responsibility for the QI program.

4.2.2 The Physician Group shall establish a QI committee, designated and overseen by Physician Group's Board of Directors or other Physician Group multi-disciplinary quality committee. The QI committee shall oversee Physician Group's QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall have adequate representation from Physician Group. The QI committee shall meet at least on a quarterly basis. Physician Group shall maintain attendance records and meeting minutes related to the QI program. Physician Group shall report in writing QI program activities to its Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.3 Physician Group's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

4.2.4 Physician Group shall develop an annual QI work plan, which includes the following:

4.2.4.1 Goals, scope, and planned projects for the year;

4.2.4.2 Planned monitoring of identified issues and tracking these issues over time;

4.2.4.3 Planned studies/audits suggested by CalOptima and/or Physician Group; and

4.2.4.4 An annual evaluation of the QI program/plan.

4.2.5 Physician Group shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans ("**CAPs**"), and reassessing the same data for improvement.

4.2.6 Requirements for the Physician Group's QI program shall be established by the Physician Group's QI committee, and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify Physician Group of any additional changes in QI standards and requirements that shall be incorporated in Physician Group's QI program. Physician Group shall not be required to change QI program requirements more frequently than once per year.

4.2.7 Physician Group shall report findings and actions taken as a result of the QI activities to CalOptima at least quarterly. In addition, Physician Group shall provide, upon request, summaries of QI committee meetings, findings following review of specific cases, and other reviews to CalOptima.

4.2.8 Physician Group shall respond promptly to all of CalOptima's requests for: (i) Medical Records; or (ii) written responses to quality-of-care issues or Member complaints.

4.2.9 Physician Group shall allow CalOptima to use performance data for various program purposes, including QI activities, public reporting to consumers, and cost sharing for QI activities, as identified in CalOptima Policies.

4.2.10 Physician Group agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Physician Group's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Physician Group's other performance trends, as applicable to Physician Group's obligations hereunder.

4.2.10.1 As long as CalOptima's disclosures under this Section 4.2.10 otherwise comply with applicable laws, no CalOptima disclosure under this Section 4.2.10 shall constitute a breach of this Contract.

4.2.11 CalOptima, at its sole discretion, may establish key performance measures to set minimum contract performance thresholds and/or implement a quality pay-for-value program that provides incentive payments to Providers who meet quality thresholds, as determined by CalOptima in its sole direction. CalOptima may additionally take the following actions, in its sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician Group, terminate this Contract, and establish Capitation Rates and other payments to Physician Group. Physician Group shall distribute at least eighty-five percent (85%) of any quality pay-for-value program payments it receives from CalOptima directly to Contracted Providers.

4.3 **Board Certification**. Physician Group shall ensure that all individual Providers furnishing Covered Services to Members meet those requirements identified in CalOptima Policies and Laws regarding board certifications, as applicable.

4.3.1 Physician Group shall ensure that any Provider who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit Claims, and/or receive reimbursement for any Covered Services furnished to Members. Physician Group shall ensure that all contracts with Providers who are subject to these requirements allow for termination of the Provider's right to furnish items and/or services, submit Claims, and/or receive reimbursement for Covered Services furnished to Members.

4.3.2 Physician Group acknowledges that these requirements apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Physician Group to furnish Covered Services to Members.

4.4 **Facility Site/Medical Records Review**. Physician Group shall comply with CalOptima Policies and Laws related to Provider site reviews, including those addressing collaborative programs.

4.5 **CLIA Laboratories**. Physician Group shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

ARTICLE 5
COORDINATION AND CONTINUITY OF CARE

5.1 **Coordination and Continuation of Care**. Physician Group shall have systems in place to ensure managed patient care, including at a minimum:

5.1.1 Management and integration of health care, including Covered Services, through a PCP.

5.1.2 Referrals for Medically Necessary specialty, secondary, and tertiary Covered Services.

5.1.3 Clearly specifying referral requirements to Contracted Providers and Subcontractors and establishing a system to track and monitor services requiring prior Authorizations through Physician Group.

5.1.4 Physician Group shall have a utilization management program that complies with CalOptima Policies and the Delegation Agreement.

5.1.5 Systems to assure provision of Emergency Services, including an education process to help assure that Members know where and how to obtain Covered Services in emergency situations.

5.1.6 The provision of Case Management Services in coordination with CalOptima's Case Management Services program.

5.1.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policies.

5.1.8 Coordinating care of certain services, including:

5.1.8.1 Ensuring that Contracted Providers document such services on the CMS-1500, UB-04 Claim form, or electronic equivalent.

5.1.8.2 Physician Group shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

5.1.8.3 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

5.1.8.4 Physician Group shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, inpatient surgical services, and inpatient hospitalization services, as provided in CalOptima Policies. Physician Group shall develop referral and prior Authorization policies and procedures to implement the above requirements. Physician Group shall submit these policies to CalOptima for review and approval;

5.1.8.5 Mental Health Services.

5.1.8.5.1 [CalOptima to draft new section to match Covered CA benefits].

5.1.8.5.2 Physician CalOptima shall share with Physician Group, in accordance with Section 13.11, any utilization data that Covered California has provided to CalOptima regarding Physician Group's coordination of care for Members.

5.2 **Contracted Provider Termination**.

5.2.1 If a Contracted Provider, including a PCP, is terminated or leaves Physician Group's network for any reason, Physician Group shall ensure that there is no disruption in services provided to Members who are receiving treatment from the Contracted Provider, including for a chronic or ongoing medical condition or long-term services and support, in accordance with applicable CalOptima Policies and Laws.

5.2.2 Physician Group shall ensure continuity and coordination of care by notifying Members affected by the termination of (i) a PCP or PCP site, or (ii) Specialist or specialty group, and assisting Members in selecting a new Contracted Provider. Physician Group shall provide notice at least thirty (30) days prior to the effective termination date or fifteen (15) days after receipt of notice of termination from a Contracted Provider, whichever provides greater notice to the affected Member(s). Physician Group shall obtain CalOptima's prior written approval before furnishing such notice. When a Contracted Provider's contract is discontinued, and either (i) the Provider or Physician Group decides to terminate the contract for reasons other than professional review actions; or (ii) the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician Group, but the rest of the group continues its contract with Physician, then Physician Group shall allow Members to have continued access to that Provider under the following circumstances and in accordance with Laws and CalOptima Policies:

5.2.2.1 Member is undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) days, whichever is shorter; and

5.2.2.2 Members in their second (2^{nd}) or third (3^{rd}) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

ARTICLE 6
PHYSICIAN FINANCIAL OBLIGATIONS

6.1 **Financial Security Reserves**. Physician Group must establish and maintain throughout the Term financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to [XX] plus a minimum of twenty-five percent (25%) of one month's Capitation Payment. Physician Group shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

6.2 **Physician Financial Responsibility for Medical Supply Items**. Physician Group shall be responsible for authorizing and paying for all injectable medications, or medications in an implantable dosage form, as set forth in Attachment A, Division of Financial Responsibility. As set forth in Attachment A, the Division of Financial Responsibilities, Physician Group shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment.

6.3 **Physician Group Payments to Providers**.

6.3.1 Capitation Payments. Physician Group and/or Subcontractors shall distribute monthly capitation payments to capitated Contracted Providers within fifteen (15) days from when Physician Group receives payment from CalOptima.

6.3.2 Claims Turnaround Time. Physician Group shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) days after receipt of the Claim from Provider, unless the Claim or portion thereof is reasonably contested by Provider, in which case the claimant shall be notified in writing that the Claim is contested or denied within thirty (30) Business Days after receipt of the Claim by Physician Group in accordance with CalOptima Policies.

6.3.3 Claims Adjudication. Physician Group shall accept and adjudicate Claims for Covered Services provided to Members in accordance with Health & Safety Code §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8; 28 CCR §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4; and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to Claims processing and payment is prohibited.

6.3.4 Dispute Resolution. Physician Group shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Health & Safety Code §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8; 28 CCR §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4; and CalOptima Policies.

6.3.5 Right of Appeal. Physician Group shall give Providers an unconditional right of appeal and de novo review for Claims disputes involving issues of Medical Necessity. Any Provider that submits a Claim dispute to Physician Group's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that Claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) Business Days from Physician Group's date of determination regarding the Claim dispute.

6.3.6 CalOptima Payment on Behalf of Physician Group.

6.3.6.1 If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) Business Days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

6.3.6.2 If Physician Group does not either notify CalOptima that the Claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) Business Day period, CalOptima shall pay the Claim on behalf of Physician Group, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

6.3.7 Assumption of Delegated Functions.

6.3.7.1 Assumption of Claims Processing. If Physician Group fails to timely and accurately reimburse Provider Claims (including the payment of interest and

penalties), CalOptima may, in its sole discretion, either assume responsibility from Physician Group for Claims payment or terminate this Contract in accordance with Section 12.2. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider Claims may be altered to the extent that Physician establishes an approved CAP consistent with Health & Safety Code § 1375.4(b)(4).

6.3.7.2 Assumption of Dispute Resolution. If Physician Group fails to resolve its Provider disputes in a timely manner, CalOptima may, in its sole discretion, either assume responsibility from Physician Group for Provider dispute resolution or terminate this Contract in accordance with Section 12.2.

6.3.7.3 Recoupment of Costs for Assumption of Claims Processing and/or Dispute Resolution. CalOptima, in its sole discretion, may reduce Physician Group's Capitation Rate to recoup additional administrative costs for the assumption of the Claims processing and/or dispute resolution responsibilities of Physician Group, as well as any amounts, including interest due, on Claims unpaid as of CalOptima's assumption of those responsibilities.

6.3.8 Quarterly Claims Payment Performance Report.

6.3.8.1 Physician Group shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("**Quarterly Claims Report**") to CalOptima within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician Group's compliance status with Health & Safety Code §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 and 28 CCR §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

6.3.8.2 Physician Group shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of a principal officer, as defined by 28 CCR § 1300.45(o), of Physician Group stating that the report is true and correct to the best knowledge and belief of the principal officer.

6.3.8.3 Physician Group's Quarterly Claims Report shall include a tabulated record of each Provider dispute received, categorized by date of receipt and include the identification of the Provider, type of dispute, disposition, and Business Days to resolution. Physician Group shall report to CalOptima each individual dispute contained in a Provider's bundled notice of dispute as a separate dispute.

6.3.9 Forwarding of Misdirected Claims.

6.3.9.1 Physician Group shall have the ability to receive a standard ANSI 837I and ANSI 837P Claim file format for retrieving misrouted Claims that are the financial responsibility of Physician Group. Physician Group shall receive and process misdirected Claims per CalOptima Policies.

6.3.9.2 Physician Group shall have the ability to create a standard ANSI 837I and ANSI 837P Claim file and forward Claims that are the financial responsibility of CalOptima within ten (10) Business Days of Physician Group's receipt of the Claim.

6.3.10 FQHC Payments. If the Provider is an FQHC, Physician Group shall reimburse the Provider at a rate comparable to any other Subcontract arrangement for similar services.

6.3.11 Certified Nurse Midwife ("**CNM**") and Certified Nurse Practitioner ("**CNP**") Payments. If there are no CNMs or CNPs in Physician Group's provider network, Physician Group shall reimburse non-contracted CNMs or CNPs for services provided to Members consistent with Laws and CalOptima Policies.

6.3.12 Family Planning Provider Payments. Physician Group shall reimburse non-contracted family planning providers consistent with Laws and CalOptima Policies. Physician Group shall reimburse non-contracted family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

6.3.13 Information Disclosures to Contracted Providers. Physician Group shall provide to all Contracted Providers – initially upon contracting, annually thereafter on or before the Contract anniversary date, and at any time upon request from a Contracted Provider – in an electronic format as defined and detailed in CalOptima Policies:

6.3.13.1 A complete fee schedule.

6.3.13.2 Payment policies and nonstandard coding methodologies used to adjudicate Claims.

6.3.14 Provider Payments.

6.3.14.1 Physician Group shall reimburse contracted Specialists for Covered Services rendered to Members on an aggregate basis.

6.3.15 Third Party Tort Liability/Estate Recovery. Physician Group shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician Group shall inform CalOptima of potential third-party liability claims and provide information relative to potential third-party liability claims, in accordance with CalOptima Policies.

6.4 **Other Health Coverage ("OHC")**. Physician Group shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician Group and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician Group cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a third-party tort liability action or make a claim against the estates of deceased Members. Physician Group shall coordinate benefits with other programs or entitlements recognizing OHC as primary.

6.4.1 Post-Payment Recovery. If Physician Group reimburses a Provider on a FFS basis, Physician Group shall pay the Provider's Claims and then seek to recover the cost of the Claim by billing liable third parties for services provided to Members with OHC Codes A or N. If Physician Group does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Physician Group shall follow the procedure in Section 6.3.1 for cost avoidance.

6.4.2 Physician Group shall have written policies implementing these Section 6.4 requirements.

6.4.3 Physician Group shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

6.4.4 Physician Group shall maintain reports that display Claims counts and dollar amounts of costs avoided and the amount of post-payment recoveries by aid category, as well as the amount of outstanding recovery Claims (accounts receivable) by age of account. Physician Group shall make these reports available to CalOptima upon request.

6.4.5 Physician Group shall identify to CalOptima any OHC unknown to CalOptima within ten (10) days of discovery in accordance with CalOptima Policies.

6.4.6 Physician Group shall demonstrate to CalOptima that, where Physician Group does not cost avoid or perform post-payment recovery, the aggregate cost of this activity exceeds the total revenues Physician Group projects it would receive from such activity.

6.5 **Medical Loss Ratio**. Physician Group shall maintain a minimum acceptable medical loss ratio, as defined by CalOptima Policies, of eighty-five percent (85%) when combined with the revenues and expenses of the Shared Risk Pool, as identified in Attachment C-2.

6.6 **Financial Viability Standards and Reporting**. Physician Group shall maintain a cash-to-Claims ratio of no less than 0.75 at all times during the Term. Physician Group shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC required under 28 CCR § 1300.75.4.2.

6.7 **Cooperation With DMHC**. Physician Group shall fully cooperate and comply with the DMHC's review and audit process and permit the DMHC to obtain and evaluate supplemental financial information related to Physician Group, in accordance 28 CCR § 1300.75.4.7. Physician Group shall also fully cooperate and participate in DMHC's CAP process, in accordance with 28 CCR § 1300.75.4.8.

6.8 **Survival**. This Article 6 shall survive the expiration or termination of this Contract regarding Covered Services provided under this Contract prior to expiration or termination.

ARTICLE 7
PHYSICIAN GROUP ADMINISTRATIVE OBLIGATIONS

7.1. **Marketing Requirements**. Physician Group shall comply with the marketing guidelines set forth in CalOptima Policies.

7.2. **CalOptima Names and Marks**. Physician Group shall not use CalOptima's name, logos, or other proprietary mark in any form without prior written approval by CalOptima.

7.3. **Member Inquiries and Calls**. Physician Group shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician Group's call center shall meet requirements established by Laws and CalOptima Policies. Physician Group shall equip and furnish its call center with appropriate telephone equipment and systems to ensure Physician Group will be able to supply call center reports required by CalOptima Policies.

7.4. **Written Member Materials**. Except as otherwise provided in this Contract, Physician Group shall ensure that all written Member information provided by Physician Group to Members is at a sixth (6^{th}) grade reading level, or as determined appropriate through the CalOptima group needs assessment. The written Member information shall ensure Members' understanding of the health plan covered services and processes and ensure the Member's ability to make informed health decisions. Written Member information shall be translated into the identified threshold and concentration languages. Physician Group shall provide written Member information in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format requested. Physician Group shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

7.5. **Credentialing Requirements**. Physician Group acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician Group. Physician Group shall have an ongoing credentialing and recredentialing program covering Contracted Providers consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Agreement in Attachment B. Physician Group shall comply with all credentialing and recredentialing obligations as specified in this Contract, CalOptima Policies, the Covered California Contract, and Laws.

7.5.1 Physician Group shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

7.5.2 Physician Group shall ensure that:

7.5.2.1 All Contracted Providers who furnish items and/or services to Members and/or submit Claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements specified in CalOptima Policies.

7.5.2.2 Any Contracted Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members.

7.5.2.3 All contracts with Contracted Providers who are subject to these requirements allow for termination of the Contracted Provider's right to furnish items and/or services to Members and/or submit Claims and/or receive reimbursement for Covered Services furnished to Members.

7.5.3 Physician Group shall provide to CalOptima, or have available for CalOptima review upon request, the following:

7.5.3.1 An annual signed attestation that all Contracted Providers who are required to meet Minimum Standards in order to furnish, submit Claims, and/or receive reimbursement for Covered Services furnished to Members meet those Minimum Standards.

7.5.3.2 An annual signed attestation that all Contracted Providers are credentialed to the standards set forth by CalOptima, Covered California, the DMHC, and Laws.

7.5.3.3 Monthly summary of all credentialing and recredentialing activity, including the name of Contracted Provider, date of facility site review (if applicable), and decision date.

7.5.3.4 Concurrent reporting of any adverse action toward a Contracted Provider, including adverse actions reported to a Regulator or other governmental agency.

7.6. **Complaints and Grievances**.

7.6.1 Member Grievance Procedures. Members or Members' authorized representatives may file grievances about any aspect of service delivery provided or arranged by a Physician Group. Physician Group shall implement and comply with CalOptima Policies and Laws relating to Member grievances and cooperate with CalOptima's and/or Regulators' investigation of any grievance. Physician Group shall take no punitive action of any kind and shall ensure that no Subcontractor takes any punitive action of any kind, against a Contracted Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

7.6.1.1 Physician Group shall provide information to Members and Contracted Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician Group has restricted, prevented, impaired, or denied the Member's free choice of Family Planning Providers.

7.6.2 Provider Grievance Procedures. Providers may file grievances about any aspect of service delivery provided or arranged by Physician Group. Physician Group shall implement and comply with CalOptima Policies and Laws relating to Provider grievances.

7.7. **Subdelegation and Subcontracting of Administrative Services**. Except as otherwise limited by the Covered California Contract, this Contract, and CalOptima Policies and subject to CalOptima's prior written approval (which it may withhold in its sole discretion), Physician Group may subdelegate to a management service organization, medical group, and/or IPA administrative functions required of Physician Group under this Contract, but such a delegation shall not absolve Physician Group of oversight responsibilities, accountability, or ultimate responsibility, obligation, and liability for the performance of those delegated functions. Accountability means that Physician cannot abdicate responsibility for the function being performed according to the requirements of this Contract and CalOptima Policies. Physician Group shall obtain approval from CalOptima of any sub-delegation pursuant to CalOptima Policies. At a minimum, Physician Group shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation with written evidence of the subdelegation, including:

7.7.1 A copy of the written subdelegation agreement that meets the requirements of this Contract and describes the relationship between Physician Group or subdelegate and the sub-delegated or sub-subdelegated entity, including the following information:

7.7.1.1 The subdelegated functions;

7.7.1.2 The responsibilities of Physician Group and the subdelegated or sub-subdelegated entity;

7.7.1.3 The frequency of the subdelegated or sub-subdelegated entity's performance;

7.7.1.4 The process by which Physician Group evaluates the subdelegated performance; and

7.7.1.5 Physician Group's remedies if the subdelegated or sub-subdelegated entity fails to fulfill its obligations, including revocation of the subdelegation.

7.7.2 A description of Physician Group's process by which the subdelegated or sub-subdelegated entity was evaluated and selected to perform the subdelegated functions, including the entity's score on a selection tool (if any).

7.7.3 A record of the Physician Group's ongoing oversight process of subdelegates and sub-subdelegates, including:

7.7.3.1 Physician Group's annual evaluation of whether the entity is performing the subdelegated functions in accordance with this Contract and NCQA standards;

7.7.3.2 Physician Group's review of the subdelegated entity's regular reports; and

7.7.3.3 Reports and data required to be submitted to CalOptima.

7.7.4 Physician Group shall terminate, as soon as practical to meet the health care needs of Members and upon receiving written notification from CalOptima, any subdelegation or sub-subdelegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract, CalOptima Policies, the Covered California Contract, or Laws.

7.7.5 Physician Group shall report to CalOptima, in accordance with all requirements established in this Contract (including Attachment B) and in CalOptima Policies, data and information that includes and encompasses all Members, including those receiving services from a subdelegate of Physician Group.

7.7.6 Physician Group shall oversee and monitor its subdelegates and sub-subdelegates and audit subdelegates no less than once in any twelve (12)-month period. Physician Group shall establish standards and performance requirements for the subdelegate function(s) and shall require subdelegates to meet or exceed all requirements of Physician Group in this Contract, CalOptima Policies, Covered California Contract, and Laws. Physician Group may be exempt from oversight, monitoring and auditing of subdelegate if the subdelegate is:

7.7.6.1 Contracted directly with CalOptima as a Health Network or physician group, or as a participant in a Health Network (*i.e.*, a shared risk group, PHC physician group, or PHC hospital), or

7.7.6.2 NCQA accredited or certified for the function(s) subdelegated by Physician Group to the subdelegate.

7.7.7 Subdelegates and sub-subdelegates failing to meet performance requirements shall be placed on a CAP. The CAP shall detail subdelegate's or sub-subdelegates deficiencies; list specific steps, tasks, and activities to bring the entity into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician Group shall promptly notify CalOptima of any subdelegate or sub-subdelegate

providing services to Members that is on a CAP. Physician Group shall provide CalOptima a copy of the CAP if requested.

7.8. **Physician Organization and Operations Structure**. Physician Group shall comply with the following organization and operations structure requirements:

7.8.1 Maintain a single board of directors and management team.

7.8.2 Have a medical director/chief medical officer ("**CMO**") providing full-time coverage with duties that shall include:

7.8.2.1 Ensuring that medical decisions are:

7.8.2.1.1 Rendered by qualified medical personnel; and

7.8.2.1.2 Are not unduly influenced by fiscal or administrative management considerations.

7.8.2.2 Ensuring that the medical care provided to Members meets acceptable standards.

7.8.2.3 Ensuring that medical protocols and standards of conduct for medical personnel are established and followed.

7.8.2.4 Developing and implementing medical care policies.

7.8.2.5 Resolving grievances related to medical quality of care in accordance with CalOptima Policies, the Covered California Contract, this Contract, and Laws.

7.8.2.6 Having a role in the implementation of QI activities.

7.8.2.7 Actively participating in the processing and resolution of grievances.

7.8.2.8 Actively participating in quality activities, including credentialing and peer Review.

7.8.2.9 Acting as a liaison and participating with CalOptima in any activities related to medical director/CMO duties.

7.8.2.10 Reporting to CalOptima within ten (10) days of any changes in the status of its medical director.

7.8.3 No employee of Physician Group, including the medical director(s) and/or CMO, that make decisions regarding the Authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding Authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence their medical judgments.

7.8.4 Maintain a single credentialing committee and create and implement credentialing policies, procedures, and standards.

7.8.5 Have a single and unified health care delivery system, including:

7.8.5.1 Contracted Providers must be accessible to all Members.

7.8.5.2 Members can select any PCP with an open panel.

7.8.5.3 PCPs can refer Members to any Contracted Provider Specialist.

7.8.5.4 Reporting to CalOptima all required data for all Members enrolled with Physician Group and its total provider network regardless of sub-delegation or other contractual relationships, including complaints, Encounter Data, utilization management data, financial reports, PCP changes, and PCP assignments.

7.8.5.5 A centralized call center receiving all Member and provider calls.

7.8.5.6 A single access number to the call center.

7.8.5.7 A Member communication standard for all Members in compliance with CalOptima Policies and Laws.

7.8.6 Other organization and operations structure requirements may be established and modified from time to time by CalOptima upon written notice to Physician Group.

7.9. **Enrollment**. Physician Group shall accept as Members all persons assigned to Physician Group through CalOptima's information system via a regular transmission from CalOptima to Physician Group.

7.10. **PCP Assignment**. Physician Group shall assign Members to a PCP within seven (7) days of the Member's assignment to Physician Group.

7.11. **Required Enrollment Information and Notice**. Physician Group shall mail to a Member or Member's head of household a notice of enrollment and a Member handbook or CalOptima-approved supplement to the CalOptima Member handbook no later than seven (7) days after receipt of notification that a Member has been enrolled with Physician Group. Physician Group shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

7.11.1 Should Physician Group choose to utilize the CalOptima Member handbook, Physician Group-specific information on each topic, as defined by CalOptima Policies, must be included in a CalOptima-approved supplement to the CalOptima Member handbook given to all Members. CalOptima shall provide Physician Group with a template for the supplement to the CalOptima member handbook.

7.11.2 If Physician Group chooses to produce and use a Member handbook other than the CalOptima Member handbook, Physician Group's Member handbook shall contain all information included in the CalOptima Member handbook and Physician Group-specific information on each topic, as required by CalOptima Policies.

7.11.3 Physician Group shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to

printing. Physician Group shall also provide one (1) copy of its enrollment information, including its Physician Member handbook or supplement, to every Contracted Provider.

7.12. **Special Disenrollment**. Physician Group may request, and CalOptima may approve in its sole discretion and according to CalOptima Policies, disenrollment for specific Members.

7.13. **Voluntary Disenrollment**. All Members have the right to disenroll from Physician Group. CalOptima shall process Member disenrollment in accordance with CalOptima Policies, the Covered California Contract, and Laws.

7.14. **Additional Services**. Physician Group shall not solicit enrollment through the offer of any compensation, reward, or benefit to Members except for additional health-related services, which have been approved by CalOptima.

7.15. **Medical and Administrative Records**. Physician Group shall require that all Subcontractors, including Contracted Providers, establish and maintain for each Member who has obtained Covered Services from a Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided, and permit peer review of the services provided. The Medical Record shall be kept in detail consistent with good medical and professional practice and that permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the Covered California Contract and Laws, as well as 28 CCR § 1300.80(b)(4) and 42 USC § 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR § 1300.67.1(c). Physician Group shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Subcontractor site.

7.15.1 Physician Group and CalOptima agree to maintain the confidentiality of information contained in the Member's Medical Records in accordance with Laws.

7.15.2 Physician Group shall ensure that Medical Records established and maintained by Physician Group and its Subcontracts, including Contracted Providers, reflect all aspects of patient care, including ancillary services, in accordance with CalOptima Policies.

7.15.3 All Physician Group's and Subcontractors' books and records pertaining to goods and services furnished under this Contract:

7.15.3.1 Shall be made available for inspection or copying at Physician Group's and/or Subcontractors' expense by CalOptima or authorized representatives of the State or federal government at all reasonable times at the Physician Group's and/or Subcontractors' place of business or at such other mutually agreeable location in the State; and

7.15.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

7.16. **Records Retention**. Physician Group and its Subcontractors shall maintain all books, documents, information, and records, including financial and accounting records, and records, notes, and documents regarding services provided under this Contract and required for the proper

administration of this Contract in accordance with Laws. Plan and Subcontractors will maintain records under this Section 7.16 for a period as required by Laws, but in no event less than the later of ten (10) years from the date the service was rendered or terminating or expiration of this Contract. Physician Group and its Subcontractors shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in this Section 7.16 or as otherwise required by Laws without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

7.17. **Access to Premises**. CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect, or otherwise evaluate the work being performed hereunder, including Subcontract-supported activities and the premises at which services are provided. If any monitoring, inspection, or evaluation is made of the premises of Physician Group or Subcontractor, Physician Group shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as to not unduly delay the work.

7.18. **Access to and Audit of Contract Records**. Throughout the Term and the retention period specified in Section 7.16, Physician Group and Subcontractors shall provide CalOptima or its Regulators access to all records and material relating to Physician Group's provision of and reimbursement for activities contemplated under the Contract and to Physician Group's financial condition and ability to bear risk under Laws. Such access shall include the right to inspect, audit, and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under Laws.

7.19. **Site Evaluations.** Physician Group shall permit CalOptima and Regulators to conduct periodic site evaluations, inspections, and onsite audits of Physician Group's facilities. CalOptima shall provide Physician Group five (5) Business Days' advance notice (or fewer if mutually agreed upon by the Parties) of any proposed site evaluation or inspection by CalOptima. If CalOptima or Regulators find any deficiencies in such facilities, Physician Group shall have thirty (30) days to correct such identified deficiencies, unless the Regulator requires that such deficiency be corrected within a shorter timeframe.

7.20. **Accreditation Surveys.** Physician Group shall cooperate with any surveys or evaluations relating to accreditation of CalOptima by any Accreditation Organization. Further, Physician Group agrees to implement any changes reasonably required as a result of all such Accreditation Organization surveys or evaluations.

7.21. **Member Request for Medical Records**. Physician Group and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Contracted Provider or a Non-Participating Provider, at no cost to CalOptima or to the Member when:

7.21.1 Such a transfer of records facilitates the continuity of that Member's care;

7.21.2 The Member is transferring from one Provider to another for treatment; or

7.21.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

7.22. **Fraud and Abuse Reporting**. Physician Group shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by Contracted Providers, Non-Participating Providers, Members, or Physician Group's employees, within five (5) Business Days of the date when Physician Group first becomes aware of or is on notice of such activity.

7.22.1 Physician Group shall notify CalOptima and shall conduct an investigation after giving notification to CalOptima.

7.22.2 Physician Group shall provide to CalOptima and/or Regulators, upon request, written policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services.

7.22.3 Physician Group shall report all investigation results to CalOptima within two (2) Business Days of conclusion of any fraud and/or abuse investigation.

7.23. **Compliance Programs**.

7.23.1 Physician Group shall develop and implement a comprehensive and effective compliance program, including the implementation of the OIG's 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Physician Group shall evaluate its compliance program annually to ensure that it remains effective and make the compliance program and related documents available to CalOptima upon request.

7.23.2 Physician Group and its employees, board members, owners, and Subcontractors furnishing medical and/or administrative services under this Contract ("**Physician Group Agents**") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and compliance plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician Group, and Physician Group shall make them available to Physician Group Agents.

7.24. **Compliance With State and Federal Programs**. Physician Group shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician Group's compliance shall include applicable requirements from Covered California, provisions of the Covered California Contract, Policy Letters, and APLs.

7.25. **Compliance With Policies and Procedures**. Physician Group agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion, in compliance with Laws. Physician Group shall timely implement CalOptima Policies applicable to its obligations under this Contract.

7.26. **Compliance With Participation Status Requirements**. Physician Group shall have policies and procedures to verify the Participation Status of Physician Group Agents. Physician Group shall refer to the HHS OIG List of Excluded Individuals and Entities (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems in the SAM System (https://www.sam.gov). In addition, Physician Group represents and warrants:

7.26.1 Physician Group and Physician Group Agents shall meet Participation Status requirements during the Term.

7.26.2 Physician Group shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion, or debarment from a State or federal program of Physician Group or Physician Group Agents occurring and/or discovered during the Term.

7.26.3 Physician Group shall take immediate action (i) to notify CalOptima, (ii) to prevent any Physician Group Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract to Members, and (iii) take any other actions required by Regulators, Government Contracts, and/or Laws.

7.26.4 Physician Group shall include the obligations of this Section 7.26 in its Subcontracts.

7.26.5 CalOptima and Physician Group, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician Group shall provide written notice to the Member who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with Laws.

7.27. **Linguistic and Cultural Sensitivity**. CalOptima will provide cultural competency, sensitivity, and diversity training. Physician Group shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

7.27.1 Physician Group shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Physician Group shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician Group shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters and how to work with interpreters. Physician Group shall also, as appropriate, refer Members to culturally appropriate community services programs.

7.27.2 Pursuant to CalOptima Policies, Physician Group shall provide translation of written member informing materials in the threshold and concentration languages. Physician Group shall comply with the language assistance standards developed pursuant to Health and Safety Code § 1367.04. Written member informing materials to be translated include: (i) signage; (ii) evidences of coverage and/or Member services guide; (iii) disclosure forms; (iv) Provider listing or directories; (v) marketing materials; (vi) form letters; (vii) CalOptima and/or Physician Group generated preventive health reminders; (viii) Member surveys; and (ix) newsletters. If a Member requests materials in a language not meeting the numeric thresholds or concentration standards, Physician Group shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician Group shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

7.28. **Provision of Interpreters**. Physician Group shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician Group or any Subcontractors, as well as member

services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician Group shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician Group shall provide twenty-four (24) hour access to interpreter services for all Members and shall implement policies and procedures to ensure compliance Contracted Providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Contracted Provider request for interpreter services in a specific situation where care is needed, Physician Group shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician Group shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's Medical Record. This documentation shall be available to CalOptima at CalOptima's request. Physician Group shall not require or suggest that a Member use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician Group shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

7.29. **Member Rights**. Physician Group shall ensure that each Member's rights, as set forth in Laws, Government Contracts, and CalOptima Policies, are fully respected and observed. Physician Group will not retaliate or take any adverse action against a Member for exercising the Member's rights.

7.30. **Contracted Provider-Member Communication**.

7.30.1 Physician Group shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its Contracted Providers to freely communicate with Members, regardless of benefit coverage, about (i) their health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; and (iv) a Member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions. Physician Group and Contracted Providers will not solicit or encourage Members to select another health plan.

7.30.2 Physician Group shall use best efforts to ensure that no employee, agent, Subcontractor, officer, director, or representative of Physician Group (i) makes any derogatory remarks regarding CalOptima to any Member or (ii) make any false statements or misrepresentations with Members. Nothing in this section shall be interpreted to discourage or prohibit Physician Group or a Contracted Provider from discussing treatment options with Members or providing other professional advice or treatment to Members deemed appropriate by a Provider acting within that Provider's scope of practice.

7.31. **Privacy Requirements**. Physician Group shall comply with all applicable Privacy Requirements and the Business Associate Agreement included in this Contract as Attachment F.

7.32. **Confidentiality of Member Information**.

7.32.1 Physician Group, its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons **whose** names or identifying information become available or are disclosed to Physician Group, its employees, agents, and/or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician Group, its employees, agents, and Subcontractors shall not use such identifying information for any purpose other than carrying out Physician Group's obligations under this Contract. Physician Group and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests not emanating from Members for disclosure of such identifying information. Physician Group shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than Covered California, the DMHC, or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identifying information shall include PHI, names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, Medical Record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web universal resource locators (URLs), internet protocol address numbers, biometric identifiers (including finger and voice prints), full face photograph images, and any other unique identifying number, characteristic or code.

7.32.2 Physician Group shall protect from unauthorized disclosure all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members. Physician Group may release Medical Records in accordance with Laws pertaining to the release of this type of information. Physician Group is not required to report to CalOptima requests for Medical Records made in accordance with Laws. With respect to any identifiable information concerning a Member under this Contract obtained by Physician Group and/or its Subcontractors, Physician Group:

7.32.2.1 Shall not use any such information for any purpose other than carrying out the express terms of this Contract,

7.32.2.2 Shall promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with Laws,

7.32.2.3 Shall, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to Physician Group by CalOptima for this purpose.

7.32.3 Family Planning. Physician Group is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential, as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning information to CalOptima, authorized representatives of the State or federal government, and/or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records.

7.33. **Confidentiality of CalOptima Information.**

7.33.1 During the Term, Physician Group may access confidential material or information ("**Confidential Information**") belonging to CalOptima. Confidential Information includes CalOptima's computer programs and codes, business plans, customer/Member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user and patient information and clinical data that comes into CalOptima's possession or control. Physician Group may only use Confidential Information to fulfill its obligations under this Contract and related internal administrative purposes. Physician Group shall protect CalOptima's Confidential Information at all times in the same manner as Physician Group protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

7.33.2 For the purposes of Section 7.33, Confidential Information does not include information that: (i) is already known to Physician Group at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of Physician Group; (iii) is independently developed without use or benefit of CalOptima's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act (Government Code Section 7920.000 *et seq*.), or other Laws.

7.33.3 Disclosure of the Confidential Information is restricted to Physician Group's Agents, who are bound by confidentiality obligations no less stringent than those in this Section 7.33, on a "need to know" basis in connection with the services performed under this Contract. Physician Group may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve Provider of its confidentiality obligations under this Section 7.33.

7.33.4 Physician Group shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of Physician Group. Those security procedures and other safeguards shall meet industry standards.

7.33.5 Upon written request of CalOptima, Physician Group shall promptly return to CalOptima or destroy all documents, notes, and other tangible materials containing CalOptima's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of Physician Group's information systems procedures, provided that Physician Group shall make no further use of such copies and continue to safeguard that information as required in this Section 7.33.

7.34. **Information and Cyber Security**. Physician Group must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

7.34.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Provider's information systems and any CalOptima information that Physician Group maintains or can access.

7.34.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Physician Group maintains or can access.

7.34.3 Security. Safeguards for the security of the information systems and CalOptima information that Physician Group maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion, and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

7.34.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

7.34.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

7.34.6 Notice. Physician Group shall notify CalOptima by email (or by telephone if Physician Group is unable to email CalOptima) within twenty four (24) hours of any use, disclosure, or access of Members' (i) PHI, (ii) personal information (as that term is defined under Civil Code § 1798.3(a), or (iii) medical information (as that term is defined under Civil Code § 56.05(j)) (collectively "**Protected Information**") that violates applicable laws and/or this Contract ("**Breach**").

7.34.7 Investigation. Physician Group shall immediately investigate the Breach and report the following to CalOptima as soon as reasonably practicable:

7.34.7.1 The Breach details, including the date of the Breach and when it was discovered;

7.34.7.2 The identification of each Member whose Protected Information was accessed, used, or disclosed during the Breach;

7.34.7.3 The nature of the data elements involved and the extent of the data involved in the Breach;

7.34.7.4 A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed Protected Information;

7.34.7.5 A description of where the Protected Information is believed to have been improperly transmitted or utilized;

7.34.7.6 A description of the probable causes of the Breach;

7.34.7.7 Whether a law enforcement official has requested a delay in notification of individuals of the Breach because such notification would impede a criminal investigation or damage national security; and

7.34.7.8 Whether any federal or State laws requiring notifying individuals of breaches were triggered.

For the purpose of this Section 7.34, "Multi-Factor Authentication" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

7.35. **Reinsurance**. CalOptima arranges for the provision of Reinsurance, as described more fully in CalOptima Policies. Physician Group may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician Group shall:

7.35.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

7.35.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

7.36. **Claims Management and Administration**. Physician Group shall have a process for Claims management and administration. Physician Group shall maintain a Claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider Claims (*i.e.*, paid, denied, pended, other), and when action was taken. Physician Group shall date stamp all Provider Claims upon receipt for all services provided to Members.

7.37. **Prohibition on Other Agreements with Hospitals**. During the Term, Physician Group shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician Group without the prior written approval of CalOptima, and upon any violation of this provision by Physician Group, this Contract shall be subject to termination pursuant to Section 12.3. of the Contract.

7.38. **Twenty-Four (24) Hour Telephone Coverage**. Physician Group shall have one (1) California Statewide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/seven (7) days a week) to obtain Authorization for all Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all threshold languages, as determined by DMHC and Covered California. The number shall connect the Member or Member's representative or Provider to an individual who shall:

7.38.1 Have authority to approve Covered Services;

7.38.2 Have the ability to transfer the Member or Member's representative to an individual with authority to approve Covered Services without disconnecting the call;

7.38.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room;

7.38.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician Group being liable for the cost of subsequent Covered Services related to that illness or injury whether or not that treatment was Authorized;

7.38.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialists, for all Members who have received a medical screening examination (within the physician's capability, including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists or Emergency Services and have been Stabilized; and

7.38.6 Shall log all calls with the time, date and any pertinent information related to persons involved, resolution, and follow-up instructions. Physician Group shall notify CalOptima if the toll-free telephone number changes no less than seven (7) Business Days prior to the change.

7.39. **Employee Education on False Claims Act**. Physician Group shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this Contract. Physician Group shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician Group's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet the requirements in 42 USC § 1396a(a)(68)(A)-(C).

7.40. **CalOptima Oversight**. CalOptima is responsible for the monitoring and oversight of all obligations of Physician Group under this Contract. If CalOptima or a Regulator determines that the Physician Group or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (i) amend or revoke the delegation of activities or obligations to the Physician Group; (ii) require the Physician Group to amend or revoke the sub-delegation of activities or obligations to the Subcontractors; and/or (iii) specify other remedies, including those set forth in Sections 12.2 and 12.3. Physician Group shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima or its Regulators determine is necessary to comply with Laws, Government Contracts, Programs, Accreditation Organization standards, and/or CalOptima Policies.

7.41. **Conflicts of Interest**. Physician Group shall comply with all CalOptima requirements and Laws pertaining to conflicts of interest, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.), and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

7.41.1 Physician Group covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during their tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. Physician Group further covenants that, for the Term, no State officer or State employee shall be employed in a management or contractor position by Physician Group within one (1) year after the State office or State employee has terminated State employment.

7.41.2 Physician Group understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, Physician Group will not be entitled to any compensation for services performed pursuant to this Contract, and Physician Group will be required to reimburse CalOptima any sums paid to Physician Group. Physician Group further understands that Physician Group may be subject to criminal prosecution for a violation of California Government Code § 1090.

7.41.3 If Physician Group becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 7.41, Physician Group shall immediately make full written disclosure of such

acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

ARTICLE 8
PHYSICIAN GROUP REPORTING OBLIGATIONS

8.1 **Data Reporting**. Physician Group shall comply with the data reporting requirements set forth in this Contract and CalOptima Policies, including the requirements specified in Standard Reporting Requirements in the Timely and Appropriate Submission Requirements from CalOptima Policies. Physician Group shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data as required by CalOptima Policies.

8.2 **Encounter Data**. Physician Group shall submit to CalOptima complete, accurate, reasonable, and timely Encounter Data (i) needed by CalOptima in order for CalOptima to meet its Encounter Data reporting requirements to Covered California, and/or (ii) required by CalOptima and Regulators, as provided in this Contract and in CalOptima Policies. Upon receiving Member assignments or changing management companies, business systems, clearinghouse vendors, and/or contractual model, Physician Group shall begin Encounter Data file testing within sixty (60) days and complete testing within ninety (90) days. Physician Group shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician Group is reporting to CalOptima less than all professional encounters in the CalOptima-required format and timelines. Physician Group shall have twelve (12) days, upon notification by CalOptima, to correct Encounter Data rejected by CalOptima or its Regulators. CalOptima shall assess penalties and/or sanctions upon Physician Group should CalOptima determine that Physician Group is not meeting the standards, as defined in CalOptima Policies, the Covered California Contract, and Laws.

8.3 **Annual Audit and Financial Reporting Requirements**. Physician Group agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) days of the completion of that year. Physician Group shall present financial statements in a form specified by CalOptima that clearly shows the financial position of Physician Group as related to Members. Physician Group shall allow representatives of CalOptima, upon written request, to verify the financial report.

8.4 **Financial Reporting**. Physician Group shall prepare financial information requested by CalOptima and/or required by the DMHC in accordance with generally accepted accounting principles (GAAP). Where financial statements and projections are requested, these statements and projections should be prepared in accordance with Laws and Regulators' requirements. Physician Group shall submit financial information consistent with filing requirements of the DMHC. Information submitted shall be based on current operations.

8.5 **Contracted Provider Network Changes**. Physician Group shall report, in compliance with CalOptima Policies, any changes, including additions, deletions, and location changes of Providers constituting Physician Group's provider network.

8.6 **Physician Organization Profile**. Physician Group shall report, in compliance with CalOptima Policies, a profile of Physician Group's organization, including Physician Group's significant administrative and Provider network contractual relationships.

8.7 **Contracted Provider Contracts**. Physician Group shall provide to CalOptima copies of all contract templates utilized with Contracted Providers. Upon modification or replacement of those

templates by Physician Group, Physician Group shall provide CalOptima with copies of the updated contract templates. In addition, upon request from CalOptima or the DMHC, Physician Group shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract. In its contracts with Contracted Providers, Physician Group shall require Contracted Providers to look solely to Physician Group for compensation for Covered Services.

8.8 **Disclosure**. Physician Group and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician Group's or Subcontractor's financial records related to Physician Group's capacity to bear the risk of potential financial losses and the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

8.9 **Reporting Unauthorized Disclosure of Private Member Information**. If Physician Group, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of "personal information", within the meaning of Civil Code § 1798.3, Physician Group shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on what was disclosed and how the disclosure occurred. For purposes of this Section 8.9, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician Group had reasonable control to avoid the disclosure.

8.10 **Provider Data**. Physician Group shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (i) needed by CalOptima in order for CalOptima to meet its reporting requirements to Regulators, (ii) as otherwise required by Regulators, and (iii) as provided in CalOptima Policies.

8.11 **Reports and Data**. In addition to any other reporting obligations under this Contract, Physician Group shall submit reports and data relating to services rendered under this Contract, in the form and manner requested by CalOptima as required by CalOptima to comply with the Covered California Contract, Laws, and any other requests from Regulators.

8.12 **Certification of Document and Data Submissions**. All data, information, and documentation provided by Physician Group to CalOptima pursuant to this Contract shall be accompanied by a certification statement on Physician Group's letterhead signed by the Physician Group's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 9
COMPENSATION

9.1 **Payment**. CalOptima shall compensate Physician Group for Covered Services and Administrative Services delegated to Physician Group, as set forth in Attachment C-1. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts

recovered through collection of Member's cost share, coordination of benefits, and stop-loss program, if applicable.

9.1.1 Capitation Payment. CalOptima shall determine the Capitation Payment by multiplying the Capitation Rate set forth in Attachment C-1 by the number of Members enrolled with Physician Group.

9.1.2 Capitation Payment Schedule. CalOptima agrees to pay Capitation Payment to Physician Group on or about the fifteenth (15th) of the month for enrolled Member. Capitation Rates shall be on a daily pro-rated basis based upon the Member's effective date of enrollment with Physician Group.

9.1.3 Capitation Payment Withhold. Pursuant to CalOptima Policy, CalOptima shall withhold from Physician Group an amount equal to twenty-five percent (25%) of a monthly Capitation Payment ("**Withhold**"). CalOptima may adjust Physician Group's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of Physician Group's current month Capitation Payment. CalOptima may increase this Withhold rate in accordance with CalOptima Policies.

9.2 **Capitation Rate Adjustments**. CalOptima may adjust the Capitation Rates during the Term to reflect implementation of State or federal laws or regulations, changes in the State budget, the Covered California Contract or Covered California policy, and/or changes in Covered Services. Payment to Physician Group is subject to Covered California providing CalOptima funds for the purposes of this Contract. Payment adjustments made by Covered California may be reflected in payments to Physician Group. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Physician Group as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

9.3 **Overpayments Discovered by Physician Group**. Physician Group shall disclose and return all Overpayments to CalOptima within sixty (60) days of when Physician Group identified the Overpayment or should have identified the overpayment through the exercise of reasonable diligence.

9.4 **CalOptima Right to Recover**.

9.4.1 Overpayments. If CalOptima determines that it overpaid an amount or paid in duplicate or that funds were otherwise paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the Parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

9.4.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid Claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including Capitation Payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.4.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (i) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including Capitation Payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (ii) sending an invoice to Physician Group that payment for such Deficits is due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

9.4.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, a Regulator finds that Physician Group (or its Subcontractors) has failed to comply with the requirements governing physician incentive plans and Regulators offset, recoup, and/or otherwise seek recovery of federal financial participation ("**FFP**"), CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (i) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including Capitation Payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (ii) sending an invoice to Physician Group that payment for such FFP amounts is due to CalOptima within thirty (30) days of Physician' Groups receipt of the CalOptima invoice.

9.4.5 Survival. This Section 9.4 shall survive the termination or expiration of the Contract.

9.5 **Additional Payment**. CalOptima reserves the right to pay Providers or Physician Group additional sums in any manner that CalOptima deems at its discretion to be beneficial for Members.

9.6 **Limitation on CalOptima's Payment Obligations**. Notwithstanding anything to the contrary in this Contract, CalOptima's obligation to pay Physician Group any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 **Member Non-Liability and Hold Harmless Requirements**. Physician Group and its Subcontractors shall comply with all Contract requirements and Laws pertaining to holding members and Regulators harmless, prohibitions on billing Members for Covered Services, or balance billing. This provision does not prohibit Physician Group or Subcontractors from collecting Member SOC, if any, as specifically provided for in this Contract or for recoveries related to OHC, as identified in Section 6.4. Physician Group or a Subcontractor may bill and collect fees for non-Covered Services from a Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician Group further agrees (i) that this Section 9.7 shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members; (ii) that this Section 9.7 shall supersede any oral or written contrary agreement now existing or hereafter entered into between Physician Group and Subcontractors; (iii) to include language from this Section 9.7 in all Subcontracts with Contracted Providers and not to revise that language without the prior written approval of CalOptima; and (iv) that, in the event of a violation of this Section 9.7 by Physician Group or Subcontractor, including balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima

shall take appropriate remedial action against Physician Group and/or Subcontractor, including repayment of any amounts collected and appropriate sanctions, as provided in Section 12.2.

9.8 **Disputes**. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts and any offset or recoupment. Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within three hundred sixty-five (365) days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of Deficits or FFP amounts by Physician Group.

9.9 **False Claims Act Policy**. Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and federal laws.

9.10 **Taxes and Contributions**. As applicable and required by Laws, Physician Group shall be responsible for withholding and paying all federal, State, and local taxes and contributions regarding (i) Physician Group's earnings under this Contract, (ii) the salaries or other benefits paid or made available to any persons retained or employed by Physician Group to furnish services under the Contract, or (iii) otherwise related to Physician Group's services under this Contract.

ARTICLE 10
CALOPTIMA OBLIGATIONS

10.1 **Financial Security Requirements**. CalOptima shall designate amounts of funds Physician Group shall establish and maintain as financial security reserves, in accordance with CalOptima Policies, the Covered California Contract, and Laws. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician Group any material deficits.

10.2 **Comprehensive Physician Group Audit**. CalOptima shall conduct and Physician Group shall agree to a full comprehensive compliance audit to be conducted at Physician Group's administrative offices and/or Facilities and/or via desktop/virtual review annually, or as otherwise deemed necessary by CalOptima. CalOptima shall submit results of the audit in writing to Physician Group. Physician Group may rebut and dispute audit findings pursuant to CalOptima Policies. Physician Group is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician Group acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician Group.

10.3 **Encounter Data Audit**. On an annual basis, CalOptima shall conduct an Encounter Data audit. The audit shall consist of CalOptima requesting a percentage of Physician Group's Medical Records. These records may be reviewed for services provided. These services may then be compared to reported encounters to determine if Physician Group accurately reported all Encounter Data.

10.4 **Policies and Procedures Availability**. CalOptima shall provide or make available for Physician Group copies of current CalOptima Policies relevant to the provisions of this Contract in hard copies, electronic files and/or on the CalOptima website.

10.5 **Release of Performance Information and Data**. Physician Group acknowledges and agrees that CalOptima may release to Providers, Members, and others, without further notice to Physician Group, information and data relating to the performance of Physician Group that CalOptima determines would contribute to Providers', Members' and others' evaluations of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.6 **Provider Complaint System**. CalOptima has established and shall maintain a fast, fair, and cost-effective complaint system for provider complaints, grievances, and appeals. Providers and Physician Group shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies. Physician Group complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system prior to utilizing the dispute resolution process in Section 13.13.

10.7 **Risk Arrangements Disclosure**. CalOptima shall provide timely notice, as required by 28 CCR § 1300.75.4.1(a)(1)-(3).

10.8 **Disclosures**.

10.8.1 Annual Financial Risk Disclosure. On the Effective Date anniversary date each year, CalOptima shall disclose to Physician Group the financial risk assumed under the Contract by providing the following information for each and every type of risk arrangement covered under this Contract:

10.8.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) allocated to Physician Group, a Hospital(s) or CalOptima under the risk arrangement.

10.8.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, Specialist, pharmacy, injectables, home health, durable medical equipment, ambulance, and other groups), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of risk arrangement.

10.8.1.3 All factors used to adjust payments or risk-sharing targets, including: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.8.1.4 The amount of payment for each service provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference and shall specify Medicare resource-based relative value scale ("**RBRVS**") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.8.2 **Annual Disclosure of Capitation Payments**. On the Effective Date anniversary date each year, CalOptima shall disclose to Physician Group the amount of Capitation Payments to be paid per Member per month.

10.8.3 **Capitation Deduction Detail**. CalOptima shall provide to Physician Group sufficient details to allow Physician Group to verify the accuracy and appropriateness of any deductions from Capitation Payments made by CalOptima, including Member name, Member number, Member date of birth, billing Provider name, date of service, procedure/service codes billed, and amount paid.

ARTICLE 11
INSURANCE AND INDEMNIFICATION

11.1 **Indemnification**. Each Party agrees to defend, indemnify, and hold the other Party and the State harmless, with respect to any claims, costs, damages, and expenses, including reasonable attorneys' fees, which are related to or arise out of the negligent or willful performance or non-performance (including fraud) by the indemnifying Party, or any functions or obligations of such indemnifying Party under this Contract. Neither termination or expiration of the Contract nor completion of the acts to be performed under this Contract shall release any Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated occurred prior to the effective date of termination, expiration, or completion.

11.2 **Insurance Requirements**.

11.2.1 Professional/Medical Malpractice. Each Contracted Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Contracted Provider provides with minimum limits as follows:

PCP or Specialist:

$1,000,000 per incident/$3,000,000 aggregate

11.2.2 Commercial General Liability/Commercial Automobile Liability. Physician Group shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:

$1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability:

$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Physician Group's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

11.2.3 Workers' Compensation. Physician Group and each Contracted Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily Injury by Accident - each accident

$1,000,000 Bodily Injury by Disease - policy limit

$1,000,000 Bodily Injury by Disease - each employee

11.2.4 Managed Care Errors and Omissions. Physician Group shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:

$5,000,000 each claim/$5,000,000 aggregate

11.2.5 Cyber Liability: Physician Group shall maintain cyber lability insurance with the minimum limits listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

Cyber Liability Insurance:

$5,000,000 each occurrence/claim and $5,000,000 aggregate

11.2.6 Insurer Ratings. Such insurance shall be provided by an insurer:

11.2.6.1 Rated by A.M. Best with a rating of A V or better; and

11.2.6.2 "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

11.2.7 Captive Risk Retention Group/Self Insured. Where any insurance(s) mentioned in this Section 11.2 is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

11.2.8 Cancellation or Material Change. The Shared Risk Pool shall not of its own initiative cause such insurance as addressed in this Article 11 to be cancelled or materially changed during the term of this Contract.

11.2.9 Proof of Insurance. Certificates of Insurance of the above insurance policies and/or evidence of self-insurance maintained by Physician shall be provided to CalOptima prior to execution of the Contract, annually thereafter, upon any change or renewal of insurance policies under this Article 11, or at CalOptima's request. Physician Group shall provide the certificates of insurance of the insurance policies referenced in this section and/or evidence of self-insurance maintained by Contracted Providers to CalOptima upon request.

ARTICLE 12
TERM AND TERMINATION

12.1 **Term of Contract**. Subject to Regulators' approval (as applicable), this Contract shall become effective on the Effective Date and will remain in effect for five (5) years ("**Initial Term**"). The Contract then shall automatically renew for additional one (1)-year terms (each a "**Renewal Term**") on the anniversary date of the Effective Date unless the Contract is otherwise terminated in accordance with this Article 12. The Initial Term together with any Renewal Term constitute the "**Term**" of this Contract.

12.2 **Sanctions and CAPs**. If Physician Group fails to fulfill any of its duties and obligations under this Contract, including (i) discriminating among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with Physician Group by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required by this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards are met; (ix) failure to enforce Claims payment prohibitions on Providers who are denied the right to submit Claims and/or receive reimbursement for services furnished to Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Contracted Providers to comply with the prior Authorization process and other pharmacy requirements, as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements, including those key performance thresholds that set minimum contract standards and/or financial incentives; (xv) failure to comply with organization structure requirements as set forth in Section 3.9 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policies; (xvi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, or (xvii) violating of the DMHC's risk bearing organization regulations, including reporting, auditing or CAP compliance violations, CalOptima may terminate the Contract under Section 12.3 or take any of the following actions:

12.2.1 CAPs. CalOptima may require a CAP if any report, audit, survey, site review, or investigation indicates that Physician Group or any Subcontractor(s) is not in compliance with any provision of this Contract or other Covered California program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician Group or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP be submitted within fourteen (14) days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which Physician Group shall correct the deficiency. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

12.2.2 General Sanctions. Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician Group does not comply with this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima.

12.2.2.1 All monetary fines are payable to CalOptima within thirty (30) days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30)-day period shall result in CalOptima deducting the penalty plus the administrative fee from Physician Group's Capitation Payment.

12.2.2.2 Physician Group may appeal CalOptima's decision to impose a sanction by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, before commencing arbitration under Section 13.13.2.

12.3 **CalOptima Termination for Cause**. CalOptima may terminate this Contract for cause effective upon thirty (30) days' prior written notice. "For cause" includes the actions set forth in Section 12.2, as well as any other material breach of a Contract provision. Physician Group may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust all administrative remedies before commencing any arbitration under Section 13.13.2.

12.3.1 In the event of a termination for cause under this Section 12.3, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Physician Group shall be liable to CalOptima for any excess costs for the provision of such similar replacement supplies or services. In addition, Physician Group shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar replacement supplies or services. CalOptima shall also charge an administrative fee when paying a Claim on behalf of Physician Group.

12.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by Laws and/or this Contract.

12.4 **Physician Group Termination for Cause**. Provided that Physician Group is not in breach of any Contract provision hereunder, Physician Group may terminate this Contract for cause upon thirty (30) days' prior written notice to CalOptima. "For cause" shall mean CalOptima's material breach or any provision under this Contract for thirty (30) days following written notice from Physician Group of the breach. Termination shall be effective at the end of the thirty (30)-day notice period, unless CalOptima remedies the breach.

12.5 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) days prior to the expiration of the Renewal Term then in effect.

12.6 **Other Grounds for Termination**.

12.6.1 Failure to Meet Quality Requirements. CalOptima may terminate this Contract immediately should Physician Group fail to comply with quality-of-care requirements established by CalOptima and/or Covered California.

12.6.2 Termination of the Covered California Contract. CalOptima may terminate this Contract immediately if the Covered California Contract terminates.

12.6.3 Loss of Waiver. This Contract shall terminate immediately upon written notice from CalOptima to Physician Group that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the SSA for County Organized Health Systems.

12.6.4 Termination for Physician Organization and Operations Structure. CalOptima may terminate this Contract immediately should Physician Group fail to comply with requirements for Physician Group's organization and operation structure established in this Contract and CalOptima Policies.

12.6.5 Insolvency. If Physician Group or its parent or holding company becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, Physician Group shall immediately notify CalOptima, and CalOptima may immediately terminate the Contract. In the event of the filing of a petition for bankruptcy by or against Physician Group, its parent or holding company, or a principal Subcontractor, Physician Group shall assure that all Physician Group's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician Group until Physician Group fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any withheld amounts as necessary to ensure that all Physician Group obligations have been met. If CalOptima becomes insolvent, Provider will have the right to terminate the Contract immediately upon written notice to CalOptima.

12.6.6 Risk to Member Health and Safety. CalOptima may immediately terminate the Contract upon written notice if CalOptima reasonably determines, in its sole discretion, that the health, safety, or welfare of Members is jeopardized by continuation of this Contract.

12.6.8 As Required by Laws. CalOptima may terminate the Contract when mandated by Laws or required by Regulators.

12.7 **Notice to Regulators**. As required by Regulators, CalOptima shall notify applicable Regulators of the termination of this Contract.

12.8 **Member and Provider Communication**. CalOptima shall approve all Physician Group communications to Members and Contracted Providers relating to termination of this Contract, prior to distribution.

12.9 **Release of Withhold**. CalOptima shall release Physician Group's Withholds to Physician Group upon the latter of nine (9) months following the Contract termination or expiration or upon CalOptima's validation of completion by Physician Group of all post-termination requirements contained in this Contract and CalOptima Policies. If Physician Group does not meet all post-termination requirements within nine (9) months following the Contract's termination or expiration, CalOptima may, at its sole discretion, use Physician Group's Withhold funds to satisfy unmet post-termination requirements.

12.10 **Release of Financial Security Requirement Deposits**. CalOptima shall release to Physician Group financial security requirement deposits no less than six (6) months following the termination or expiration of this Contract unless termination is the result of Physician Group insolvency. CalOptima shall release to Physician Group financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician Group's insolvency.

12.11 **Obligation Upon Termination**. Upon termination or expiration of this Contract, Physician Group shall continue to provide Authorized Covered Services to Members who retain eligibility and are under the care of Physician Group at the time of such termination or expiration, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the Contract's termination or expiration, CalOptima shall pay Physician Group at the rates applicable to such services in effect under the Contract immediately prior to termination. The provision of or payment for services after the termination of the Contract shall not be construed as a renewal of this Contract for any further term or a rescission of any Contract termination. Termination shall not affect any rights or obligations hereunder that previously accrued or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Contract.

12.12 **Termination and Transfer of Care**. Prior to the termination or expiration of this Contract, and upon request by Covered California or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and records to Covered California or a successor State contractor, Physician Group shall make available to Covered California and/or CalOptima copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members and the preservation, to the extent possible, of Member-Provider relationships.

12.12.1 Physician Group agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of record and data reproduction shall be borne by Physician Group.

12.13 **Termination Plans**. Physician Group shall have a plan for the orderly termination of services under this Contract. CalOptima may review and approve Physician Group's termination plans at intervals and frequencies established by CalOptima Policies. Physician Group shall submit a plan regarding coordination of care and payment of Claims to CalOptima at least sixty (60) days prior to termination or expiration of this Contract. The termination plan requires the written approval of CalOptima.

12.14 **Prohibition on Use of Certain Providers**. Physician Group agrees:

12.14.1 CalOptima reserves the right to require Physician Group, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the prohibition under this section shall not terminate this Contract.

12.14.2 CalOptima requires that Subcontractors who do not meet all Minimum Standards be prohibited from furnishing items or services and/or submitting Claims and/or receiving reimbursement for items and/or services furnished to Members.

ARTICLE 13
MISCELLANEOUS

13.1 **Interpretation of Contract Language**. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

13.2 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, employees, or agents shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

13.3 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be provided in a manner that does not constitute a waiver of immunity or privilege under Laws.

13.4 **Governing Law and Venue**. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the Covered California Contract. Subject to Section 13.13, Physician Group must bring all legal proceedings against CalOptima in State courts located in the County, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

13.5 **Amendment**.

13.5.1 Except as otherwise provided in Section 13.5.2, the Parties may only amend this Contract in a written amendment signed by both Parties.

13.5.2 Regulatory Amendment. CalOptima reserves the right to amend or terminate the Contract at any time when such modifications or terminations are (i) mandated by changes in Laws; (ii) required by Government Contracts; or (iii) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall notify Physician Group in writing of such Regulatory Change promptly and in accordance with applicable federal and/or State requirements, and Physician Group shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date, unless otherwise instructed by a Regulator, including Covered California.

13.5.3 Board Approval. Any extension, renewal, or modification of this Contract shall be subject to formal approval by CalOptima's Board of Directors.

13.6 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

13.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

13.8 **Force Majeure**. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of XX (XX) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

13.9 **Assignment, Assumption, and Change of Control**. Physician Group may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 13.9, assignment includes: (i) the change of more than fifty percent (50%) of the directors or trustees of Physician Group; (ii) the merger, reorganization, or consolidation of Physician Group with another entity when Physician Group is not the surviving entity; or (iii) a change in the management of Physician Group from management by persons appointed, elected or otherwise selected by the governing body of Physician Group (*e.g.,* the Board of Directors) to a third-party management person or entity. In addition, Physician Group must obtain CalOptima's prior written consent for any change of control. For purposes of this Section 13.9, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in Physician Group (whether in a single transaction or in a series of transactions).

13.10 **No Liability of County of Orange**. As required under County Ordinance No. 3896, as amended, CalOptima and the Physician Group hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County shall have no obligation or liability therefore.

13.11 **Notices**. Any notices required or permitted under this Contract shall be in writing and delivered to the addresses set forth below in this Section 13.11. Any notice not related to termination of this Contract may be sent electronically to the other Party's e-mail address listed in this section or such other address as may be provided by a Party to the other Party from time to time. If notice relates to termination of this Contract, such notice shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service that delivers to the noticed destination and provides proof of delivery to the sender. All notices sent to the addresses set forth in this section shall be effective (i) when first received by the Party, or (ii) upon refusal of delivery by the Party to which it was sent. Any Party whose address changes during the Term shall promptly notify the other Party in writing. If CalOptima cannot complete notice under this Section 13.11 because Physician Group's addresses are incorrect and/or Physician Group failed to notify CalOptima of the change, CalOptima shall provide notice under this Section 13.11, including for Contract termination, by making commercially reasonable efforts to deliver notice in any manner reasonably calculated to give Physician Group actual notice, and notice shall be deemed delivered upon the completion of those efforts.

To: CalOptima
Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

[insert email]

To: Physician Group
_____
_____
_____
_____

13.12 **Government Claims Act**. Subject to this Section 13.12, Physician Group shall ensure that Physician Group and Physician Group Agents comply with the applicable provisions of the Government Claims Act (California Government Code § 900 *et seq*.), including Government Code §§ 910 and 915, and CalOptima Policy AA.1217.

13.13 **Dispute Resolution**.

13.13.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 13.13.2.

13.13.2 Arbitration. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Section 13.13.1, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

13.13.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 13.13.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes. Notwithstanding the foregoing, either Party may institute proceedings in a federal or state court of competent jurisdiction to seek temporary or preliminary injunctive relief to enforce the status quo in any dispute relating to this Contract pending the resolution of that dispute through arbitration.

13.13.4 Waiver. By agreeing to binding arbitration as set forth in Section 13.13.2, the Parties acknowledge that they are waiving certain substantial rights and protections that otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

13.14 **Injunctive Relief**. If Physician Group breaches any provision of this Contract, CalOptima shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Contract, including injunctive relief without the necessity of posting bond.

13.15 **Confidential and Proprietary Information**. Physician Group agrees to maintain confidential the following information (the "**Confidential Information**"): (i) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Members; (ii) CalOptima's administrative service manuals and all forms related thereto; (iii) the financial arrangements between CalOptima and any Participating Provider; and (iv) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Physician Group in writing. Physician Group shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Physician Group may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination or expiration of this Contract, Physician Group shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

13.16 **Third Party Beneficiaries**. Except as required by Government Contracts, nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

13.17 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 7.2, 7.16, 7.17, 7.18, 7.21, 7.22, 7.31, 7.32, 7.33, 7.34, 8.1, 8.2, 8.3, 8.9, 8.10, 8.11, 8.12, 9.1, 9.3, 9.4, 9.6, 9.7, 9.8, 9.10, 11.1, 12.3, 12.5, 12.7, 12.9, 12.10, 12.11, 12.12, 12.13, 13.1, 13.2, 13.3, 13.4, 13.6, 13.7, 13.10, 13.11, 13.12, 13.13, 13.14, 13.15, 13.16, 13.17, 13.18, 13.19, 13.20, and any other sections that, by their terms, are intended to survive termination of the Contract.

13.18 **Recitals and Exhibits**. The recitals, attachments, and exhibits set forth in this Contract are made a part of the Contract by this reference.

13.19 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

13.20 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

13.21 **Authority to Execute**. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract, the Parties are formally bound.

13.22 **Execution**. This Contract may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument. Subject to the State and United States providing funding during the Term and for the purposes with respect to which it is entered into, execution of the Government Contracts, and the approval of the Contract by Regulators, this Contract shall become effective as of the Effective Date.

[*signature page follows*]

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Contract as indicated below.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer _____
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A

CALOPTIMA COVERED CALIFORNIA PROGRAM
DIVISION OF FINANCIAL RESPONSIBILITY

This Attachment A identifies how CalOptima allocates to Physician Group components of the medical costs associated with the provision of Covered Services. That is, the Capitation Payment rates in this Contract are based upon Physician Group being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima Evidence of Coverage or EOB for making coverage determinations.

SERVICES	SHARED RISK SERVICES BUDGET (Between Group and Plan) GROUP		PLAN
Facility - Not Otherwise Assigned Herein		**X**	
Professional - Not Otherwise Assigned Herein	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic (Refer to Hearing)	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			
Professional Component	**X**		

Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		**X**	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		**X**	
Chemical Dependency Rehabilitation and Detox			
Professional Component		**X**	
Facility Component – Outpatient freestanding location		**X**	
Facility – Hospital based		**X**	
Methadone outpatient clinics		**X**	
Chemotherapy			
Drugs – Outpatient, if provided in physician office setting		**X**	
Drugs – Oral taken by patient			**Rx**
Professional Component	**X**		
Facility Component – Outpatient freestanding location	**X**		
Facility Component – Hospital based		**X**	
Chiropractic	**X**		
Dental Services (When Medically Necessary)			
Professional Component	**X**		
Facility Component		**X**	
Anesthesia	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing, includes pathology, radiology cardiac studies, and sleep studies			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Covid-19 diagnostic and screening testing	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room (In Area)			
Facility Component		**X**	
Professional Component (including interpretive reports)	**X**		
Endoscopy			
Facility Component		**X**	
Professional Component	**X**		

Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		**X**	
Professional Component	**X**		
Fetal Monitoring			
Facility Component		**X**	
Professional Component	**X**		
Gender Affirming Services (also known as Gender Reassignment), including vocal modification surgery when medically necessary			
Facility Component		**X**	
Professional Component	**X**		
Psychotherapy			**X**
Hormone Therapy			**Rx**
Speech Therapy	**X**		
Electrolysis, and laser hair removal, when medically necessary	**X**		
Genetic Testing/Counseling	**X**		
Health Education	**X**		
Hearing Aids	**X**		
Hearing Screening / Exam	**X**		
Hemodialysis/Dialysis			
Outpatient (Includes drugs)		**X**	
Professional Component	**X**		
Home Health Care			
Home health services (Including home IV therapy, excluding Part D drugs)		**X**	
Home Health Supplies (see medical supplies)		**X**	
Hospice			
Inpatient Facility		**X**	
Professional	**X**		
Home Hospice		**X**	
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		**X**	
Interpretive Reports	**X**		
Professional Component (Including hospital-based physicians)	**X**		

Immunization and Inoculations (Immunizations for the purpose of traveling are not covered)	**X**		
Infusion Therapy			
Professional Component	**X**		
Facility Component		**X**	
Drugs – if provided in physician office setting		**X**	
Drugs - if provided in other than physician office setting		**X**	
Injectables -- (Outpatient) (see also Chemotherapy)			
Drugs – if provided in physician office setting		**X**	
Drugs - if provided in other than physician office setting		**X**	
Lithotripsy			
Professional Component	**X**		
Facility Component		**X**	
Mammography	**X**		
Maternity/Obstetrics			
Facility Component		**X**	
Professional Component	**X**		
Medical supplies (includes catheters)			
Outpatient	**X**		
Medication			
Outpatient – Prescription Drug Benefit, including self-administered drugs			**Rx**
Outpatient -Provider Administered Drugs in freestanding site		**X**	
Outpatient - Provider Administered Drugs in Hospital or ASC setting		**X**	
Mental Health			
Facility Component (includes Partial Hospitalization)		**X**	
Professional Component			**X**
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		**X**	
Outpatient, Facility Component	**X**		
Professional Component	**X**		
Nutrition			
Nutritional/Dietetic Counseling	**X**		
Parenteral Nutrients, Supplies, Kits and Pumps		**X**	
Outpatient	**X**		
Inpatient		**X**	

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Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient	X		
Inpatient		X	
Organ Transplants			
Pre-Evaluation (All Inclusive)	X		
Organ Acquisition		X	
Transplant Professional Component	X		
Transplant Facility Component (includes organ acquisition)		X	
Post Transplant (up to one year for transplant related services)			
Professional Component	X		
Post Transplant Facility Component (Inpatient)		X	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	X		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient	X		
Ostomy Supplies			
Outpatient	X		
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		X	
Professional Component		X	
Outpatient Diagnostic Tests and Services (All Inclusive)	X		
Outpatient Surgery			
Facility Component (Hospital Based)		X	
Facility Component (Freestanding Ambulatory Surgery Center)		X	
Professional Component	X		
Cardiac catheterization and Angiograms (Professional)	X		
Cardiac catheterization and Angiograms (Facility)		X	
Physical Therapy (See Rehabilitation)			
Pain Management			
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services	X		
Radiation Therapy			
Professional	X		

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Facility, Outpatient hospital		**X**	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	**X**		
Inpatient (facility component)		**X**	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	**X**		
Professional Component	**X**		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		**X**	
Professional Component	**X**		
Surgically Implanted Devices – All Categories		**X**	
Urgent Care Center (Inclusive of all settings)			
In Area – Professional and Facility	**X**		
Out of Area – Professional	**X**		
Out of Area - Facility		**X**	
Vision Care			
Annual routine exam, including exam for refractive diagnosis			**X**
Contact lenses, frames, and lenses,			**X**
Lenses and Frames incidental to cataract surgery (Medicare covered)	**X**		
Screening, Physician Office	**X**		
Notes:			
1. Financial responsibility is based on Evidence of Coverage benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT B

DELEGATION AGREEMENT

For purposes of the Delegation Agreement in this Attachment B, [insert Health Network name] shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment B for CalOptima and its Members assigned to Delegate.

This Attachment B shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. **Definitions**

   a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; Covered California, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. **Delegate Obligations**

   a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, and D, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment B and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment B requiring approval by either party.

   b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service before implementation and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and written approval by CalOptima before implementation. Delegate agrees to provide CalOptima with thirty (30) days' prior written notice of material changes to Delegate's policies and procedures.

   c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to and approval by CalOptima. Delegate shall provide CalOptima with a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin, in accordance with CalOptima Policies. Delegate shall notify CalOptima no later than sixty (60) days before any changes to the list of subdelegates, vendors, subcontractors, or offshore entities and/or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment B and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment B and its Schedules A, B, C, and D (as applicable). Delegate represents and warrants that

it shall take all steps necessary to cause subdelegates to comply with this Attachment B, including all Schedules.

d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

iii. Delegate and offshore entity consent to and cooperate with CalOptima Policies and CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

iv. CalOptima and Delegate must file the proposed subdelegation of functions or services of the approved offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment B. All systems processing and/or storing of PHI and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment B and the duties and obligations under this Attachment B, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment B have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in

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the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment B or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment B and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c) the standards of any applicable Accreditation Organization. In the event CalOptima or an Accreditation Organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) days of receiving notice of such change or within such time frame as may be required by the Accreditation Organization, Standards and Requirements, or CalOptima. The Parties agree any such change or revision shall not be considered a change to a material term of this Attachment B, consistent with Section 2.a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract, (a) compensation to persons performing any Delegated Services under this Attachment B shall not contain incentives or remuneration, direct or indirect, in cash or in-kind, to those persons to make inappropriate decisions that result in underutilization; and (b) compensation or remuneration to persons performing such functions under this Attachment B shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors' and any downstream entity organization's operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use CalOptima's code of conduct and training or an equivalent); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more

than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment B.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) days' prior written notice or upon shorter notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment B or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP is approved by CalOptima, Delegate will be required to implement, within ten (10) Business Days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 14.

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable Accreditation Organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least ten (10) days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment B and for six (6) years thereafter (or longer if required by law), with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable Accreditation Organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment B with five (5) days' advance notice for routine monitoring and one (1) day notice

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for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable Accreditation Organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA and other Accreditation Organizations to conduct on-site review of any documents related to services provided by Delegate under this Attachment B during a health plan accreditation survey of CalOptima by NCQA or other Accreditation Organization. Cooperation with such NCQA or other Accreditation Organizations, on-site review, and accreditation survey shall include permitting NCQA or other Accreditation Organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. **Records and Confidential Information**

a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable Accreditation Organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

a. As outlined in Schedules A, B, C, and D, as applicable.

b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

c. CalOptima shall provide Member experience and clinical performance data to Delegate on an on-going basis. Member experience data shall be provided at least annually and include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies. Clinical performance data shall be provided monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. **Claims Payment Delegation:**

a. **Timely Adjudication of Claims:**

i. Delegate will process Claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code § 1371, 28 CCR §§ 1300.71 and 1300.77.4.

ii. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process Claims on Delegate's behalf, then Delegate shall: (A) immediately notify CalOptima of such delegation, and (B) require the Subcontractor to comply with the Claims processing procedure requirements in this Attachment B and Standards and Requirements.

b. **Claims Forwarding**: If Delegate receives a Claim for services provided to a Member and the Claim is the financial responsibility of CalOptima or another Health Network or Provider, Delegate shall timely forward the Claim to CalOptima or the applicable Health Network or Provider within ten (10) Business Days pursuant to 28 CCR § 1300.71(b)(3).

c. **Failure to Make Payment:** Notwithstanding anything in this Attachment B, if Delegate fails to pay a Provider for Covered Services that are Delegate's financial responsibility under the Contract within the time frames outlined in this Attachment B and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) Business Days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

a. **Timely Decisions Made by Appropriately Licensed Professionals:** Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written using sixth (6^{th}) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

c. **UM Information Integrity:** At all times during the Term, Delegate shall maintain detailed policies and procedures regarding UM information integrity that meet all Standards and Requirements. Delegate's UM information integrity policies and procedures will (i) define how Delegate audits UM information for inappropriate documentation updates and implements corrective actions that address identified information integrity issues, and (ii) describe how compliance with the information integrity policies and procedures is monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

    a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by a medical director, designated physician, or the Credentialing Committee.

    b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within: one hundred eighty (180) days of credentialing for files processed prior to July 1, 2025, and one hundred twenty (120) days of credentialing for files processed on or after July 1, 2025, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

    c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable Standards and Requirements that include the range of actions available to the Delegate and how they make appeal processes known to Providers.

    d. **Credentialing Information Integrity**: At all times during the Term, Delegate will maintain detailed policies and procedures regarding credentialing information integrity that meet all Standards and Requirements. The credentialing integrity policies and procedures will (i) define how Delegate audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified Information Integrity issues, and (ii) how compliance with these policies and procedures is monitored and enforced.

    e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal and/or OneCare program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members, including medical management, discharge planning, Members, caregivers, and individual Practitioners. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

    b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Network Management Delegation**: Delegate will maintain an adequate network of primary care and specialty care practitioners and will monitor access and availability for its Members.

a. **Notification of Termination**

i. Delegate shall use information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

ii. Delegate shall notify Members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics at least thirty (30) days prior to the effective termination date, and help Members select a new practitioner.

b. **Continued Access to Practitioners**

i. If Delegate discontinues a contract with any practitioner, Delegate shall allow affected Members continued access to the practitioner in accordance with Laws and Standards and Requirements, including the following:

1. Continuation of treatment through the current period of active treatment, or for up to ninety (90) days, whichever is less, for Members undergoing active treatment for a chronic or acute medical condition.

2. Continuation of care through the postpartum period for Members in their second or third trimester of pregnancy.

13. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) Business Days and shall complete the training within thirty (30) days of placing them on Active Status. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

14. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment B are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment B, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

15. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP , or delegation failures that could jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

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a. **Freeze Delegate Enrollment and/or Pause Auto-Assignment:** CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to implement a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

   i. Per Member sanctions of $25,000 per Member:

      1. Delegate fails to provide medically necessary services that the Delegate is required to provide.

      2. Delegate inappropriately delays/denies Covered Services.

      3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.

      4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.

      5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

   ii. Aggregate sanctions for failures that impact populations of Members

      1. One percent (1%) off the monthly capitation amount for a first violation.

      2. Two percent (2%) off the monthly capitation amount for a second violation.

      3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

   iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

   iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process, as outlined in CalOptima Policies.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. **Modification of Delegation:** If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable

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satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice, CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment B.

f. **Termination of Delegation with Notice:** Notwithstanding Section 14(e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. **Immediate Termination of Delegation:** Notwithstanding Sections 14(e) and 14(f) of this Attachment B, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment B. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. **Material Breach**: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment B shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment B shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

16. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment B, the following provisions shall apply:

a. **CalOptima's Assumption of Payment of Claims:** If Delegate's Claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment B, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of Claims that are Delegate's financial responsibility under this Attachment B. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code § 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment B, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather, the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

Utilization Management/ Case Management	3.0%
Credentialing	1.0%
Claims Processing	
- non-contracted only	1.0%
- all Claims	7.0%
- non-contracted only payment withhold *	8.5%
- all Claims payment withhold	85.0%

* = Subject to actual Claims paid experience.

c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment B to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

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Schedule A
Claims Payment Delegation

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Claims policies, procedures, and compliance	Covered California	1. Annually submit updated, reviewed, and approved Claims payment policies and procedures. 2. Provide oversight to any Subcontractors and subdelegated entities that perform Claims processing or payment to ensure compliance with Standards and Requirements. 3. Submit all required reports and audit materials, as defined in Schedule A.	1. Establish, publish, and distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted to CalOptima's Delegation Oversight Committee ("Delegation Oversight") as part of the annual audit: 1. Updated, reviewed, and approved Claims processing policies and procedures. 2. Evidence of oversight of Subcontractors and subdelegates.	Annual audit, or more frequently as needed, using NCQA methodology for Program Audit Protocols for Covered California line of business ("LOB"). Delegate must meet at a minimum ninety-five percent (95%) compliance for each LOB.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
Claims processing		1. Identify and acknowledge electronic Claims within two (2) Business Days of receipt. 2. Identify and acknowledge paper Claims within fifteen (15) Business Days of receipt. 3. For Covered California Claims, process and adjudicate ninety-five percent	1. Annual Claims audits, or as often as necessary, and ongoing performance monitoring.	Submitted via monthly XML process: 1. Claims XML Universe. 2. Claims Universe Case Files.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for	1. CAP 2. Remediation steps as outlined in Section 15, Attachment B.

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Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		(95%) of Clean Claims for Covered Services within thirty (30) days of receipt. a. Process and adjudicate all other Clean Claims from non-Participating Providers for Covered Services within sixty (60) days from date of receipt. b. Process and adjudicate ninety-nine percent (99%) of all Clean Claims from Participating Providers for Covered Services within ninety (90) days of receipt.	2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	3. Claims Timeliness Report.	Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	
Exclusion and preclusion monitoring		1. Verify Practitioner or Provider entity participation status prior to adjudicating any received Claims as required by CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring. 2. If Delegate pays a Claim from an excluded Practitioner or Provider entity, Delegate must notify CalOptima, recover the payment, and prevent future payments to the excluded Provider.	1. Establish, publish, and distribute Standards and Requirements for delegated activity.	N/A	N/A	1. CAP 2. Remediation steps as outlined in Section 15, Attachment B.
Interest payment for late paid Claims		Covered California: 1. Pay interest and applicable penalties on all uncontested Claims not paid within thirty (30) days. 2. For emergency services, automatically include the greater of fifteen dollars ($15) for each twelve (12)-month period (or portion thereof) on a non-prorated	N/A	N/A	Annual audit, or more frequently as needed, using NCQA Methodology for Program Audit Protocols for	1. Corrective Action Plan (CAP) 2. Remediation steps as outlined in Section 15,

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Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		basis, or interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 3. For all other late payments, include interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 4. If Delegate fails to include the interest due on a late Claim payment, the Delegate shall pay an additional ten-dollar ($10) penalty.			Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	Attachment B.
Coordination of benefits		1. Have processes and procedures in place to identify payers that are primary and secondary to determine amounts payable and coordinate benefits for members with OHC, in accordance with Laws and Covered California and DMHC Claims guidelines. 2. Identity and report to CalOptima any OHC or other private or public health insurance for Members. 3. Identify and report to CalOptima any explanation of payment ("**EOP**") or explanation of medical benefits ("**EOMB**") received with other coverage payment.	1. Annual Claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Monthly Post Payment Recovery Template.	Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Third party liability		1. Notify CalOptima within five (5) days of becoming aware of potential third-party liability (including casualty insurance, tort, workers compensation liability) related to Covered Services for a Member.	1. Annual Claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Report occurrences consistent with CalOptima Health Policy FF.2007: Reporting of Potential Third-Party Liability.	Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
Level 1 Provider dispute resolution		1. Acknowledge receipt of electronically submitted Level 1 disputes within two (2) Business Days; acknowledge receipt of hard-copy disputes within fifteen (15) Business Days after receipt of a complete provider dispute resolution. 2. Resolve Level 1 provider disputes or amended disputes related to Claims payment decisions within forty-five (45) days after receipt of a complete provider dispute resolution.	N/A	N/A	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
					Delegate must meet at a minimum ninety-five percent (95%) compliance.	

Schedule B

Utilization Management Delegation

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Program policies, procedures, and compliance	Covered California	1. Annually submit updated, reviewed, and approved written UM Program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. 2. Conduct an annual evaluation of the UM Program that verifies the program meets all Standards and Requirements, ensures all UM decisions are made by qualified professionals, evaluates the appropriateness of UM criteria, assesses the interrater reliability, ensures the criteria are consistently applied and available to Providers, and ensures all denials are reviewed by a physician or other appropriate professional. 3. Provide oversight to any Subcontractors and/or subdelegated entities that perform UM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	1. Establish, publish, and distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Annual UM Program and Workplan. 2. Semi-Annual Work Plan. 3. Annual UM Evaluation. 4. Annual UM Evaluation (Prior year). 5. All required documents for Annual Audit pursuant to the CalOptima Reporting Policy.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM decision timeliness	Covered California	Comply with all Standards and Requirements for notification of UM decisions, including CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. Further, Delegate will make UM decisions in a timely manner and notify Providers and Members electronically or in writing: 1. Urgent concurrent and preservice decisions within seventy-two (72) hours of request. 2. Non-urgent pre-service decisions within five (5) Business Days from receipt of information reasonably necessary to render a decision, but no longer than fourteen (14) days from request. 3. Post-service decisions within thirty (30) days of request.	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via monthly XML process: 1. Utilization Management (UM) XML Universe.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
UM decision clinical information	Covered California	1. Gather and use all clinical information relevant to the Member's care when making UM decisions. 2. Adhere to policies set forth in CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines.	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute	Submitted via XML: 1. Utilization Management (UM) XML Universe.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	
Written notification of UM denials and appeal rights	Covered California	Delegate shall comply with all Standards and Requirements for written notification applicable for Covered California, including CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall use a readability scoring tool and ensure notices for Members do not use language exceeding a sixth (6^{th})-grade level. Further, written or electronic notification of UM denials for Members and Providers must include the following: 1. The specific reason for the denial in easily understood language. 2. A reference to the benefit provision, guideline, protocol, or other similar criteria upon which the denial is based. 3. A statement that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via XML: 1. Utilization Management (UM) XML Universe.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		criteria on which the denial decision is based, upon request. 4. The Provider notice must be addressed to the requesting Provider (not organization) and include the name and direct telephone number, if available, or general number and extension of the decision maker. 5. A description of appeal rights, including the right to submit written comments, documents, or other relevant information. 6. An explanation of the appeal process, including Members' rights to representation and time frames. 7. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials, including: a. Timeframe for filing; b. Timeframe for decision; and c. Process for expedited appeal, including where to direct appeal and what information to include. 8. Notice that expedited external review can occur concurrently with internal appeals process for urgent care.				

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Information Integrity	Covered California	Delegate has UM information integrity policies and procedures, audits UM information for inappropriate documentation, and updates and implements corrective actions that address identified information integrity issues: 1. The scope of UM information. a. UM requests from Members or their authorized representatives. b. UM request receipt date c. Appropriate practitioner review. d. Use of board-certified consultants. e. Clinical information collected and reviewed. f. UM decision. g. UM decision notification date. h. UM denial notice. 2. Staff responsible for completing UM activities. a. For documenting the completion of UM activities, authorized to modify UM information and oversight of UM information integrity functions, including auditing.	1. Pre-delegation system review. 2. Annual review of Delegate information integrity policies, training, audit and analysis report. 3. Review annual UM program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activities. 5. Review all required reports timely and provide	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		3. The process for documenting updates to UM information. a. Specify when updates to existing UM information is appropriate b. Describe process for documenting the following when updates are made to UM information. Staff who updated the information, when, what and why the information was modified. 4. Inappropriate documentation and updates with falsifying credentialing information. 5. Audits UM staff and the process for documenting and reporting identified information integrity issues. 6. At least annually train UM staff on: a. Inappropriate documentation and updates and updates, annual audits and process for documenting and reporting inappropriate documentation and reporting consequences. 7. At least annually audits and analyzes for inappropriate documentation and updates to UM denial receipt and notification dates and conduct qualitative analysis. 8. Improvement Actions:	substantive feedback.			

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Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		a. Delegate implements actions to address all inappropriate documentation and updates found during the audit. 9. Conducts and audits the effectiveness of corrective actions on the findings 3-6 months after completion of the annual audit, if applicable.				
Level 1 Provider dispute resolution	Covered California	1. Process and resolve Level 1 Provider disputes related to post-service UM decisions according to Standards and Requirements, including CalOptima Policies.	1. Annual audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via XML: 1. UM Retrospective Post-Service Decision Universe.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Schedule C

Case Management Delegation

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Case management activities	Covered California	1. [List of CM activities delegated as of date of the Attachment B] 2. Changes necessary to comply with new/revised Laws and Standards and Requirements will not be considered a change to a material term of this Attachment B requiring approval by either party.	[List of CM activities retained by CalOptima]	N/A	N/A	N/A
Case management policies, procedures, and compliance	Covered California	1. Annually submit updated, reviewed, and approved written Case Management ("**CM**") program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. CM program shall include basic care management, care coordination, complex care management services, and transitional care services. 2. Conduct an annual evaluation of the CM program that verifies the program meets all Standards and Requirements, ensures the appropriate identification, stratification, and management of members. 3. Provide oversight to any subdelegated entities, vendors, or consultants that	1. Pre-delegation reviews. 2. Annual CM program audits, or as often as necessary. 3. Quarterly case file audits. 4. Establish, publish, and distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide	All required documentation for CM program annual audit. Submitted via FTP: 1. Monthly Case Management Log. 2. Quarterly case files as identified by CalOptima.	Annual program audit or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Quarterly case file review.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		perform CM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	substantive feedback if appropriate.			
Case management program referral	Covered California	Delegate identifies Members with multiple or complex health care conditions, obtains access to care, and coordinates their care. Delegate has multiple referral programs, including: 1. Medical management. 2. Discharge planning. 3. Member or caregiver. 4. Practitioner.	1. Pre-delegation reviews. 2. Conduct quarterly case file reviews or as often as necessary. 3. Establish, publish, and distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback if appropriate.	Submitted via FTP: 1. Monthly Case Management Log. 2. Quarterly case files as identified by CalOptima.	Quarterly case file review, or more frequently as needed, using NCQA Methodology. Delegate must meet a minimum of 75% compliance for two consecutive quarters. Score is the combined percentage of each audited case.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
Case management systems	Covered California	Delegate uses a CM system that supports: 1. Evidence-based clinical guidelines to conduct initial assessment and ongoing management.	1. Pre-delegation reviews. 2. Establish, publish, and	All required documentation for CM program annual audit.	N/A	1. CAP 2. Remediation steps outlined in Section 15,

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Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. Automatic documentation of date, time and individual who takes action on a case or interacts with a Member. 3. Automated prompts for follow-up.	distribute Standards and Requirements for delegated activity.			Attachment B.

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Schedule D

Credentialing Delegation

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing policies, procedures, and compliance	Covered California	Annually, Delegate will submit updated, reviewed, and approved written Credentialing Program documentation outlining the credentialing process for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and CalOptima contract provisions. The program documentation must specify: 1. Types of Providers to credential and recredential. 2. Verification sources. 3. Criteria for credentialing and recredentialing. 4. Process for making credentialing or recredentialing decisions. 5. Process for managing credentialing files that meet Delegate's criteria. The process for managing credentialing must also include files that do not meet the organization's criteria. 6. The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, publish, and distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	Submitted to Delegation Oversight annually via the audit process: 1. Credentialing program documentation.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		by the credentialing committee or other designated peer-review body. 7. Non-discrimination policies and procedures. 8. Delegate must identify the process for notifying practitioners if information obtained during the credentialing process varies from what was provided 9. The credentialing and recredentialing decision must be done within thirty (30) days. 10. Roles and direct responsibility of Delegate's Medical Director or other designated physician in the Credentialing Program. 11. Confidentiality policies and procedures. 12. Policies and procedures designed to ensure accuracy of provider directories to include the highest level of education, training, board certification and specialty. 13. Delegate must have a process for documenting information and activities in credentialing files. Using either of the following methods or a combination:				

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		a. Credentialing documents signed (or initialed) and dated by the verifier b. A checklist that includes, for each verification, the source used, date of verification, signature or initials of the person who verified the information, and report date, if applicable. c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification source used and report date, if applicable. 14. Delegate will notify Practitioners about their right to review information about their application, correct errors, and check status of the application. 15. How Delegate considers Provider performance during recredentialing, including Member complaints/grievances.				

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		16. Demonstrates compliance with CalOptima policies regarding credentialing of all provider types GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.				
Credentialing Committee	Covered California	Delegate will operate a Credentialing Committee that makes recommendations regarding credentialing and re-credentialing decisions: 1. Committee is comprised of Participating Providers. 2. Reviews credentials for Providers who do not meet thresholds established by the Committee. 3. Ensures that files that meet Credentialing Committee-established criteria are reviewed and approved by a Medical Director, designated physician, or Credentialing Committee.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, publish, and distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	N/A	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section , 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Organizational Providers		The Delegate shall assess and approve, initially and in an ongoing manner, Provider organizations. Before the Delegate contracts with an organizational Provider, and for at least every thirty-six (36) months thereafter, it: 1. Confirms that the Provider is in good standing with state and federal regulatory bodies. 2. Confirms that the Provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the Provider is not accredited.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, publish, and distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
Verification of credentials		Delegate will conduct timely verification within one hundred eighty (180) days of credentialing of information (or a shorter time frame as required by Standards and Requirements) to ensure Providers have the legal authority and relevant training and experience to provide quality care to Members. Delegate will verify	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring.	1. Credentialing Monthly Universe.	Annual audit, or more frequently as needed using NCQA methodology for Program Audit	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		credentialing information through primary sources, unless otherwise indicated. Delegate will conduct timely verification within one hundred twenty (120) days of credentialing of information. 1. All National Provider Identifier (NPI) numbers, where applicable. 2. A current and valid license to practice. 3. A valid DEA or CDS certificate, as applicable. 4. Education and training, consistent with Standards and Regulations. 5. Board certification status, as applicable. 6. Work history. 7. History of professional liability claims that resulted in settlements or judgements paid on behalf of practitioner. 8. Sanction information: a. OIG; b. System for Award Management (SAM); and c. CMS Preclusion List.	2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	
Credentialing applications		Delegate will require Providers to submit a credentialing/re-credentialing	1. Annual Credentialing Program audits,	N/A	Annual audit, or more frequently as	1. CAP 2. Remediation steps as

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		application that includes a signed attestation that includes: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. The application must include practitioner race, ethnicity, and language. The application must inform practitioners this information is optional and that the delegate does not discriminate, penalize or base CR decisions on this information. 7. The application's accuracy and completeness. 8. Hospital admitting privileges at a CalOptima contracted hospital, or if Delegate is financially responsible for Hospital services, a Delegate-contracted Hospital. 9. Practice coverage, including names of answering service and covering physicians.	or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	outlined in Section 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Recredentialing cycle	Covered California	1. Delegate will recredential Participating Providers within thirty-six (36) months of their prior approval date. 2. In between recredentialing cycles, Delegate will perform ongoing monitoring and interventions between recredentialing cycles and take appropriate action against Providers when Delegate identifies occurrences of poor quality. Monitoring shall include collecting and reviewing limitations on licensure, complaints, and information of adverse events. 3. Re-credentialing must include documentation that Delegate has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, Member grievances, and medical record reviews.	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Credentialing Universe is sent Bi-Annually 2nd of March and September	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps as outlined in Section 15, Attachment B.
Ongoing Monitoring and Interventions	Covered California	Delegate has a process in place to monitor practitioners between credentialing cycles using the following: 1. Sanctions, limitations, and expiration on licensure using at least one of the following sources: a. NPDB b. FEHB	1. Annual credentialing program audits, or as often as necessary, and ongoing performance monitoring.	N/A	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program	1. CAP 2. Remediation steps as outlined in Section 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		c. State agencies d. FSMB e. State licensure or certification board 2. Practitioner-specific Member complaints and evaluates practitioner's history of complaints 3. Adverse events at least monthly a. Investigates all practitioner complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable and b. Evaluate the history of all complaints for all practitioners at least every 6 months Delegate must have criteria in place to determine issues to be taken to its credentialing committee arising from these five areas listed above and provide evidence of reporting to the credentialing committee	2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Actions against Providers	Covered California	1. Delegate has policies and procedures for taking actions against Providers that include the range of actions available to Delegate and how it	1. Annual Credentialing Program audits, or as often as	1. Delegate must report any Business & Professions Code	Annual audit, or more frequently as needed using	1. CAP 2. Remediation steps outlined in Section 15,

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		makes appeal processes known to Providers. These policies and procedures establish that the majority of the appeal panel are peers of the Provider in question, and prohibit Delegate from attorney representation at appeal hearings unless the Provider is also represented. 2. If Delegate takes action against a Provider for quality reasons, Delegate will report the action to the appropriate authorities and offers a formal appeal process. 3. Delegate will use objective evidence and patient care considerations to decide on altering a Provider's relationship with Delegate if the Provider doesn't meet Delegate's quality standards.	necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	§§ 805 and/or 805.01 actions immediately to CalOptima Quality Improvement Department at MyCredentialingUpdates@caloptima.org.	NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	Attachment B.
Identification of HIV/AIDS Specialists	Covered California	Delegate has policies and procedures for identifying HIV/AIDS Specialists: 1. Documentation describes how the Delegate identifies and annually reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California regulations. 2. Documents that Delegate provides list of qualified Specialists to	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring.	N/A	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		department responsible for authorizing standing referrals.	3. Establish, publish, and distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Delegate must meet at a minimum ninety-five percent (95%) compliance.	
Credentialing Information Integrity	Covered California	Delegate has credentialing information integrity policies and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues: 1. Delegate's policies specify protection of each of the following types of credentialing information: a. The practioner application and attestation b. Credentialing documents received from the source or agent, c. Documentation of credentialing activities	1. Pre-delegation reviews. 2. Annual credentialing program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activities.	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum of ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		d. Credentialing committee minutes e. Documentation of clean file approval, if applicable. f. Credentialing checklist, if used. 2. The staff responsible for performing credentialing activities: a. For documenting credentialing activities, authorized to modify credentialing information and oversight of credentialing information integrity functions. 3. The process for documenting updates to credential information. a. Specify when updates to existing credentialing information is appropriate b. Describe Delegate's process for documenting the following when updates are made to credential information. Staff who updated the information, and when, what and why the information was modified.	4. Review all required reports timely and provide substantive feedback.			

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		4. Inappropriate documentation and updates with falsified credentialing information. 5. Audits credentialing staff and the process for documenting and reporting identified information integrity issues. 6. At least annually train credentialing staff on : a. Inappropriate documentation and updates, annual audits, and process for documenting and reporting inappropriate documentation and reporting consequences. 7. At Least Annual Audits and Analyses: a. For inappropriate documentation and updates to credentialing information and conduct qualitative analysis. 8. Improvement Actions: a. Delegate implements corrective actions to address all inappropriate documentation and updates found during the audit. b. Delegate conducts an audit of the effectiveness of corrective actions on the findings 3-6				

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Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		months after completion of the annual audit.				
Subdelegation of credentialing	Covered California	If Delegate subdelegates (subject to CalOptima's prior written approval) credentialing functions to another entity, Delegate will perform oversight of the subdelegated relationship in accordance with all Standards and Requirements, including: 1. Using a written delegation agreement including all Standards and Requirements. 2. Performing a pre-delegation review prior to implementation of Contract, including credentialing information integrity. 3. Requiring at least semi-annual reporting. 4. Having a written process that Delegate will use to evaluate subdelegated entity's performance. 5. Describing to subdelegate remedies available to Delegate if subdelegate does not fulfill its obligations. 6. Identify and follow-up on opportunities for improvement, if applicable.	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, publish, and distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	N/A	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps as outlined in Section 15, Attachment B.

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Schedule E
Network Management Delegation

Delegated Network Management Activity	LOB	Delegated Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Notification of Termination	Covered California	Delegate uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. Delegate notifies Members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) days prior to the effective termination date, and helps them select a new practitioner.	Annual Audits or as often as necessary and ongoing monitoring.	Submitted via FTP Site: Provider Termination Quarterly Report	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum of ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.
Continued Access to Practitioners	Covered California	If a practitioner contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to ninety (90) days, whichever is less, for members undergoing active treatment for a	Annual Audits or as often as necessary and ongoing monitoring.	Submitted via FTP Site: Provider Termination Quarterly Report	Annual audit, or more frequently as needed using NCQA methodology for Program Audit Protocols for Covered California LOB. Delegate must meet at a minimum of ninety-five	1. CAP 2. Remediation steps outlined in Section 15, Attachment B.

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		chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy			percent (95%) compliance.	

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ATTACHMENT C-1

CAPITATION RATES

Payments by CalOptima to Physician Group for Covered Services rendered to Members in accordance with the Contract shall be on a per Member/per month ("**PMPM**") basis at the rates outlined below, except for carved out services and items as provided for in CalOptima Policies.

Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
00-00 year, Both			
01-14 years, Both			
15-18 years, Female			
15-18 years, Male			
19-39 years, Female			
19-39 years, Male			
40-64 years, Both			
65+ years, Both			

Overall Average Capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima Policies. The Parties agree that the above rates compensate Physician Group for all services outlined in Attachment A, *CalOptima Division of Financial Responsibility*. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to Physician Group to cover the additional Covered Services required by such declared public health emergency.

ATTACHMENT C-2

SHARED RISK PROGRAM

1. Shared Risk Pool. CalOptima and Physician Group are establishing the Shared Risk Pool as described in CalOptima Policy FF.1010, Shared Risk Pool, which shall be administered by CalOptima and separately accounted for on CalOptima's books. Any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract between the Parties and any expenses from a previous Shared Risk Period received after the end of that previous Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

1.1. Shared Risk Services—Definition. "**Shared Risk Services**" means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("**Shared Risk Hospital Amount(s)**"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as "high-cost exclusions", shall not be included in Shared Risk Services.

1.2. Shared Risk Budget. In addition to the Hospital Budget capitation allocation to the Shared Risk Pool set forth in Section 1 of this Attachment C-2, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) supplemental obstetrics (OB) delivery care payments as set forth in CalOptima Policy FF.1005f, Special Payments: Supplemental OB Delivery Care Payment, and (b) per CalOptima Policy FF.1007, Health Network Reinsurance Coverage, any Reinsurance coverage amounts collected or allocated. Shared Risk Expenses (as defined in Section 1.3 below) shall be the actual amounts paid for Shared Risk Services less any recoveries, including overpayments.

1.3. Shared Risk Expenses. Monthly, during the Term, the following expenses and charges ("**Shared Risk Expenses**") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Pool Hospital amounts paid to Hospitals for Shared Risk Services provided to Members, (b) an estimated amount of IBNR expense (defined in Section 1.4.2 below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (c) administrative expenses at a rate of [XX] per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses.

1.4. Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

1.4.1. Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined in Section 1.5 below), CalOptima shall produce a written report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool during that quarter and the Shared Risk Period to

date. Each quarterly report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5 of this Attachment C-2) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2. Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period (as defined in Section 1.5 below), CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget allocations made in that semi-annual period minus Claims paid for services rendered in that semi-annual period minus a full allocation for incurred but not reported ("**IBNR**") Claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician Group, from the Hospital Budget allocation, an amount equal to [XX] of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5. Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("**Shared Risk Period**").

1.5.1. Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account IBNR expenses, regardless of when paid, provided that only those expense items received within ninety (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2. Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "**Budget Deficit**"), an amount equal to sixty percent (60%) of such Budget Deficit, plus the amount of any semi-annual distributions, shall be carried forward as a charge against any future distributions under Section 1.5.3 of this Attachment C-2.

1.5.3. Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "**Budget Surplus**"), an amount equal to sixty percent (60%) of such Budget Surplus shall be paid to Physician Group by CalOptima only after any semi-annual distributions have been deducted from the sixty percent (60%) of the Budget Surplus allocable to Physician Group.

1.5.4. If Physician Group elects to move from existing contracted shared risk group model to another contract model, Physician Group's Shared Risk Pool shall not be in deficit.

2. Reports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

   Physician Group shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30)-day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the thirty (30)-day review period.

3. Settlement in the Event of Termination. Notwithstanding anything in this Attachment C-2 or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 12 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) days following the termination in accordance with Section 1.5 of this Attachment C-2 and Section 9.3 of the base Contract.

4. Obligations of Physician Group. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician Group shall provide CalOptima with a report in a form acceptable to CalOptima and in accordance with CalOptima Policies. If, in CalOptima's reasonable opinion, Physician Group consistently fails to provide such reports to CalOptima, Physician Group shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against Claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used. Year-end IBNR will be calculated using Claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "Claims paid through" date, and subsequent Claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

6. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 12.2 of the Contract.

ATTACHMENT D

CALIFORNIA REGULATORY REQUIREMENTS

I. Covered California Requirements

1.1 **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Section I.

1.2 **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("**QHP**") issuer to provide Administrative Services or health care services to qualified individuals and their dependents.

1.3 **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides Administrative Services or health care services to qualified individuals and their dependents.

1.4 **Emergency Medical Condition** means the same as the definition of "emergency medical condition" set forth in HSC § 1317.1.

1.5 **Emergency Services**, **Medically Necessary**, and **Medical Necessity** shall have the same meanings as in Article 1 of the Contract.

1.6 **Compliance.** Physician Group agrees to be bound by all provisions of the Qualified Health Plan Issuer Contract between CalOptima and Covered California ("**QHP Contract**") that are applicable to the services Physician Group and its Contracted Providers provide to CalOptima. Physician Group agrees to comply with all Laws, including the federal Patient Protection and Affordable Care Act, (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), known collectively as the Affordable Care Act; the California Patient Protection and Affordable Care Act, Assembly Bill 1602 and Senate Bill 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010); the Americans with Disabilities Act of 1990 (42 USC §§ 12101 *et seq*.); the Anti-Kickback Statute (42 USC § 1320a–7b); the Public Contracts Anti-Kickback Act (41 USC §§ 51 *et seq*.); the Stark Law (42 USC § 1395nn); the Knox-Keene Health Care Service Plan Act of 1975 (HSC §§ 1340 *et seq*.); the Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq*.); all Laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200 of Part 5 of Division 9 of the Family Code); Public Contract Code Section 10295.3 with regard to benefits for domestic partners; environmental laws, rules, and regulations applicable to Physician Group's operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30 (commencing with Section 42460 of the Public Resources Code) relating to hazardous and solid waste; and any and all other State and federal Laws, rules, and regulations applicable to the operation of Covered California, the QHP Contract, and Physician Group's provision of services under the Contract. Physician Group will incorporate such applicable requirements in Physician Group's contracts with its Subcontractors, including the provisions under § 4.4.1(d) of the QHP Contract. [QHP Contract §§ 1.2(c), 1.3(b), 1.13, 4.4.1(b)-(d)]

1.7 **Nondiscrimination in Administration of Services and Benefits.** Physician Group and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557

(42 USC § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d *et seq*.), Title IX of the Education Amendments of 1972 (20 USC §§ 1681 *et seq*.), the Age Discrimination Act of 1975 (42 USC §§ 6101 *et seq*.), Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), or subject to any other applicable Laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health Product or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xv), 1.10(a)]

1.8 **Conflict of Interest.** Physician Group agrees to be free from any conflicts of interest with respect to Covered Services provided under the Contract. Physician Group and its personnel shall not currently have, and shall not have throughout the Term, any direct interest that may present a conflict in any manner with the performance of services required under the Contract. Physician Group represents that it is not aware of any conflict of interest or any basis for potential violations with respect to Laws that govern referrals required for the provision of certain Covered Services, including federal and State Anti-Kickback and Anti-Self-Referral Laws. [QHP §§ 4.4.1(d)(xvi), 1.11]

1.9 **Nondiscrimination in Workplace.** Physician Group and its agents, employees, and Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome, mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), aged forty (40) or over, marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Physician Group and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Physician Group and its agents and employees shall comply with the provisions of the California Fair Employment and Housing Act (Government Code § 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 10000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12900, set forth in CCR Chapter 5 of Division 4 of Title 2, including 2 CCR §§ 11102 *et seq*., are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician Group shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]

1.10 **Privacy and Security Requirements for Personally Identifiable Data.** Physician Group agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 USC §§ 1320d *et seq*., HITECH, and any current and future regulations promulgated under HIPAA or HITECH, all as amended from time to time and collectively referred to herein as the "**HIPAA Requirements**." Physician Group agrees not to use or further disclose any PHI, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this section that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(a); 45 CFR § 155.260(b)(2)(v)]

1.10.1 Physician Group shall, and shall require that its Subcontractors, maintain technology policies and procedures acceptable to CalOptima that provide reasonable safeguards to protect PHI and Personally Identifiable Information

stored, maintained, or accessed on hardware and software utilized by Physician Group and its Subcontractors. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(b)(ii)(7)(e)]

1.10.2 Physician Group shall, and shall require that its Subcontractors, comply with all applicable Exchange Protection of Information policies in accordance with the terms and conditions set forth in Section 10.2 of the QHP Contract, Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(b)(ii)(7)(h), 10.2]

1.10.3 If Physician Group or its Contracted Providers will have access to PHI and/or Personally Identifiable Information that is received from, created, or received by CalOptima on behalf of Covered California or in connection with the QHP Contract, Physician Group and its Contracted Providers shall be bound by the same or more stringent restrictions, terms, and conditions as those that apply to CalOptima pursuant to the QHP Contract with respect to such PHI and Personally Identifiable Information; provided, however, that any restrictions that are more stringent shall be set forth in the Contract. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(f)(i)]

1.10.4 Physician Group shall mitigate to the extent practicable, any harmful effect that is known to Physician Group of any Security Incident related to PHI and/or Personally Identifiable Information or of any use or disclosure of PHI and/or Personally Identifiable Information by Physician Group in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(b)(ii)(7)(f)]

1.10.5 Physician Group shall cooperate with CalOptima and Covered California in investigating any Breach and/or successful Security Incident involving PHI and/or Personally Identifiable Information and in meeting CalOptima's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving PHI and/or Personally Identifiable Information is attributable to Physician Group or its Contracted Providers, Physician Group shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and CalOptima. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(e)(iii)]

1.10.6 In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of CalOptima, Physician Group agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR Part 162. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(f)(iv)]

1.10.7 Physician Group shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of PHI and/or Personally Identifiable Information by Physician Group or its Subcontractors or agents, including (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) State law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of the Breach and to respond to the Breach; (b) mitigate harm to the affected

Individual(s); and (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of PHI and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(Xi), 10.1(f)(vi)]

1.11 **State Agency Reviews.** Physician Group agrees that Covered California, the California Department of General Services, State Auditors, other State and federal regulatory agencies, or their designated representatives shall, subject applicable Laws regarding the confidentiality and release of Protected Heath Information of Members, have the right to review and to copy any records and supporting documentation pertaining to the performance of the QHP Contract. Physician Group agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. Physician Group agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(Xii), 11.5(c)]

1.12 **Performance Standards.** Physician Group shall comply with all QHP Contract requirements and performance measurement standards, including those related to customer service that are applicable to Covered Services. CalOptima shall provide performance measurement standards to Physician Group. CalOptima may impose penalties for failure to comply or otherwise act in accordance with applicable performance standards of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xix), Article 7]

1.13 **Clinical Records.** Except with respect to any longer periods that may be required under Laws, Physician Group and its Contracted Providers will maintain a clinical record documentation system adequate to fully disclose and document the medical condition of each Member, to the extent applicable to the services, and the extent of Covered Services provided to each Member by Physician Group and/or its Contracted Providers. Clinical records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by Laws, if an audit, litigation, research, evaluation, claim, or other action involving records has not concluded before the end of the seven (7)-year minimum retention period, Physician Group and its Contracted Providers shall retain the clinical records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(i) & (Xii), 11.1]

1.14 **Claims Data.** Physician Group shall cooperate with CalOptima's obligations under the QHP Contract to maintain historical Claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from the date that the QHP Contract is terminated with respect to Covered Services provided to Members during the term of the QHP Contract. These records shall include the data elements required to produce specific reports mutually agreed upon by Covered California and CalOptima and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable Regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductibles, out-of-pocket costs, and other cost-sharing for each Claim. [QHP Contract §§ 4.4.1(d)(xiv) and (xii), 11.2(c)]

1.15 **Financial Records.** Financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by Physician Group in connection with the QHP Contract shall be retained by Physician Group for at least ten (10) years from the date of the final Claims payment, unless a longer maintenance period is required by Laws or the QHP Contract. Physician Group shall maintain accurate books, accounts, and records and

prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to Physician Group. This shall include (i) adequate data customarily maintained and reasonably necessary to properly document each of Physician Group's transactions with CalOptima and Contracted Providers during the period the QHP Contract remains in force, and (ii) records of Claims, including medical review and high dollar special audit Claims. [QHP Contract §§ 1.12, 4.4.1(d)(xiv), (Xii), 11.2(a), 11.2(b)]

1.16 **Books and Records Location.** Books and records shall be kept in a secure location at Physician Group's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by CalOptima, Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10)-year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(Xii), 11.3]

1.17 **Notice.** Physician Group shall promptly notify CalOptima in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Physician Group, personnel, Subcontractors, or its Contracted Providers that is threatened or commenced by any governmental authority or other party that a reasonable person might believe could materially affect the ability of CalOptima to perform in accordance with the terms set forth in the QHP Contract. [QHP Contract §§ 4.4.1(d)(Xii), 11.6]

1.18 **Scope of Licensure.** All Covered Services must be provided by duly licensed, certified, or accredited Providers consistent with the scope of their Licenses and in accordance with Law, the standards of medical practice in the community, and the terms set forth in this Contract and the QHP Contract. [QHP Contract § 4.4.1(a)]

1.19 **QHP Contract Requirements.** Physician Group agrees to be bound, and to bind each of its Subcontractors, by all provisions of this Contract and the QHP Contract that are applicable to the Covered Services that Physician Group and its Subcontractors provide or arrange for the provision of under the Contract [QHP Contract § 4.4.1(d)], including:

1.19.1 Coordination with Covered California and other programs and stakeholders.

1.19.2 Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and CalOptima's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].

1.19.3 Participating Provider directory requirements [QHP Contract § 4.4.4].

1.19.4 Symphony Provider directory requirements [QHP Contract § 4.4.5)].

1.19.5 Implementation of processes to enhance stability and minimize disruption to the provider network [QHP Contract § 4.3.3].

1.19.6 Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].

1.19.7 Provider credentialing, including maintenance of licensure and insurance [QHP Contract § 3.4.2].

1.19.8 Customer service standards [QHP Contract § 4.6].

1.19.9 Utilization management [QHP Contract § 5.3].

1.19.10 Maintenance of a corporate compliance program [QHP Contract § 1.2].

1.19.11 Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].

1.19.12 Appeals and grievances [QHP Contract § 4.6.2].

1.19.13 Member and marketing materials [QHP Contract § 3.2].

1.19.14 Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.12], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].

1.19.15 Nondiscrimination [QHP Contract § 1.10].

1.19.16 Conflict of interest and integrity [QHP Contract § 1.11].

1.19.17 Other Laws [QHP Contract § 1.13].

1.19.18 Advancing equity, quality, and value to the extent applicable to Contracted Providers [QHP Contract Article 5], including disclosure of contracting arrangements with Contracted Providers as required pursuant to Attachment 1, Advancing Equity, Quality, and Value, to the QHP Contract.

1.19.19 Performance measures, to the extent applicable to Participating Providers [QHP Contract Article 7].

1.19.20 Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.3 and Article 8].

1.19.21 Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].

1.19.22 Maintenance of books and records [QHP Contract Article 11].

1.20 **Cooperation.** Physician Group recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, CalOptima, Physician Group, and any other authorized Subcontractors. Physician Group shall coordinate and cooperate with CalOptima and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. Physician Group shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of the California Healthcare Eligibility, Enrollment, and Retention System with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other Laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.6]

1.21 **Subcontractor Selection.** Physician Group shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any CalOptima approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable Laws, rules, regulatory requirements, and orders. Physician Group's obligations pursuant to this Contract and applicable Laws shall not be waived or released if Physician Group is permitted to subcontract or otherwise delegate services of this Contract. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]

1.22 **Independent Contractors.** Nothing in the QHP Contract or this Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Physician Group or

CalOptima and Physician Group. The Parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]

1.23 **Provider Directory.** Physician Group shall provide information to CalOptima to allow CalOptima to comply with its provider directory obligations under the QHP Contract. Physician Group acknowledges that Covered California may use Physician Group's and its Contracted Providers' data for any noncommercial purpose. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

1.24 **Member Liability.** Physician Group shall comply with Laws governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if CalOptima fails to pay an amount owed by CalOptima to Physician Group. Physician Group shall inform every Member in a manner that allows the Member the opportunity to act upon Physician Group or a Provider's proposal or recommendation regarding (i) the use of a Non-Participating Provider or (ii) the referral of a Member to a Non-Participating Provider for proposed non-Emergency Services. Physician Group shall disclose to a Member considering accessing non-Emergency Services from a Participating Provider if a Non-Participating Provider will be used as part of the Participating Provider's plan of care. Physician Group is responsible for complying with the Provider Manual and may rely upon CalOptima's provider directory in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]

1.25 **Credentialing.** If Physician Group is delegated activities relating to credentialing and recredentialing, the process used by Physician Group must be reviewed and approved by CalOptima and as otherwise required by DMHC or any other applicable Regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]

1.26 **Utilization Management.** Physician Group shall cooperate and comply with and participate in the UM Program established by CalOptima in compliance with Laws, including HSC § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]

1.27 **Eligibility and Enrollment Determinations.** Physician Group shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to CalOptima in its efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2, Article 3]

1.28 **Grievances and Appeals.** Physician Group shall cooperate and comply with the internal review process established by CalOptima to resolve Member written or oral grievances and Appeals, including those involving expressions of dissatisfaction regarding Physician Group or a Provider. Physician Group shall comply with State and federal Laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2]

1.29 **Quality, Network Management, and Delivery System Standards.** Physician Group shall cooperate and comply with programs established by CalOptima consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to CalOptima to ensure CalOptima's compliance with its required reporting obligations pursuant to Attachment 1, Advancing Equity, Quality, and Value, of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]

1.30 **Customer Service Standards.** Physician Group shall comply with all applicable QHP Contract customer service standards that are applicable to Physician Group. [QHP Contract §§ 4.4.1(d)(viii), 4.6]

1.31 **Continuity of Care.** Physician Group agrees to comply with CalOptima Policies implemented to enhance stability and minimize disruption to CalOptima's provider networks. Physician Group shall provide CalOptima with the information necessary to comply with notice and other requirements in the cases of block transfers (HSC § 1373.65) and network disruptions (HSC §§ 1373.23 and 1366.1). In the event of a change related to network disruption, block transfers, or other similar circumstances, Physician Group shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under Laws, including those relating to continuity of care set forth at HSC § 1373.95 and as otherwise set forth in the QHP Contract. In the event of termination of the QHP Contract or decertification of one or more of CalOptima's QHPs, Physician Group shall cooperate fully with CalOptima and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(X), 4.3.3, Article 8]

1.32 **Fraud, Waste, and Abuse Programs.** Physician Group shall maintain compliance and provide CalOptima with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance of its obligations and CalOptima's reporting obligations under the QHP Contract. [QHP Contract §§ 4.4.1(d)(x), 1.2, 1.15]

1.33 **Insurance.** Physician Group shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable Laws. [QHP Contract § 9.1.3]

1.34 **No Surprises Act.** Physician Group shall comply and will ensure its Contracted Providers comply with the Consolidated Appropriations Act of 2021 rules against surprise billing (the "**No Surprises Act**"), including complying with applicable cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections. If Physician Group is responsible for processing Claims for Covered Services rendered by out-of-network providers, Physician Group shall process such Claims in accordance with the No Surprises Act. [HSC § 1371.9; 45 CFR §§ 149.410, 149.420, 149.430, 149.440]

1.35 **Health Plan Accountability.** Notwithstanding any relationship CalOptima may have with Physician Group, as Delegated Entity, and any Downstream Entity, CalOptima maintains responsibility for its compliance, as well as the compliance of Physician Group and any Downstream Entity, with all applicable standards enumerated at 45 CFR § 156.340(a). [45 CFR § 156.340(a)]

1.36 **Delegated Entity and Downstream Entity Compliance.** If any of CalOptima's issuer activities and obligations, in accordance with 45 CFR § 156.340(a), are delegated to Physician Group, then Physician Group, as Delegated Entity, agrees to the following provisions and Physician Group further agrees that it will require Downstream Entities to comply with the same standards. [45 CFR § 156.340(b)]

1.37 **Standards for Downstream and Delegated Entities.** The Contract, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. [45 CFR § 156.340(b)(1)]

1.38 **Revocation of Delegated Activities.** In the event the HHS or CalOptima determines, in its sole discretion, that Physician Group or any Downstream Entity have not performed the

delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR § 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or CalOptima, as applicable. [45 CFR § 156.340(b)(2)]

1.39 **Compliance with Laws.** Physician Group will perform such activities and obligations in compliance with all applicable Laws and regulations relating to the standards specified in 45 CFR § 156.340(a). (45 CFR § 156.340(b)(3))

1.40 **Right to Audit.** Physician Group and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the Office of the Inspector General, or their designees, to evaluate through audit, inspection, or other means, Physician Group's or the Downstream Entity's books, contracts, computers, or other electronic systems, including Medical Records and documentation, relating to CalOptima's obligations in accordance with the standards enumerated at 45 CFR § 156.340(a), as applicable, until ten (10) years from the final date of the Contract period. (45 CFR § 156.340(b)(4)-(5))

1.41 **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits CalOptima from entering into a contract with a provider, network or association of providers, third party administrators, or other service providers offering access to a network of providers that would directly or indirectly restrict CalOptima from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or Members, or individuals eligible to become participants, beneficiaries, or Members of the plan or coverage; (ii) electronically accessing de-identified Claims and Encounter Data for each participant, beneficiary, or Member; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Contract, Physician Group agrees that CalOptima is in compliance with this provision with respect to this Contract and nothing in this Contract will prohibit CalOptima from complying with this provision.

II. DMHC Requirements

2.1 **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of Health & Safety Code ("**HSC**") 1367.03 and 28 CCR § 1300.67.2.2, and in a manner that provides continuity of care, including the availability of PCPs who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or provider to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and State Laws. Physician Group and its Contracted Providers shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Physician Group or its Contracted Providers have any role in rendering Emergency Services, Physician Group and/or its Contracted Providers will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Physician Group and its Contracted Providers shall provide reporting required by CalOptima and DMHC necessary to ensure compliance with DMHC accessibility and network adequacy standards. Physician Group and its Contracted Providers will comply with CalOptima's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments.

[HSC §§ 1367, 1367.03, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]

2.2 **Licensure and Certification**. As applicable, Physician Group and its employed and contracted personnel shall be licensed and certified by their respective board or agency, where licensure or certification is required by law to provide services under the Contract. As applicable, any equipment used by Physician Group and/or its employed and contracted personnel under the Contract required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. [H&S Code § 1367(b)-(c)]

2.3 **Coordination of Member Care.** Physician Group and its Contracted Providers are responsible for coordinating the provision of health care services to a Member if Physician Group or a Contracted Provider is acting as the Member's PCP. Physician Group and its Contracted Providers shall maintain Member Medical Records in a readily available manner that permits sharing with CalOptima of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]

2.4 **Provider Directory Information.** Physician Group shall inform CalOptima within five (5) Business Days of material changes that would affect its or its Contracted Providers' listing in CalOptima's provider directory, so that CalOptima can comply with HSC § 1367.27. Material changes include:

2.4.1 The addition or deletion of a Provider.

2.4.2 A change in a Provider's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.

2.4.3 Whether Physician Group or its Contracted Providers are or are not accepting new patients.

If Physician Group or one of its Contracted Providers is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Physician Group or that Provider shall direct the Member or potential Member to CalOptima for additional assistance in finding a provider and to DMHC to report any inaccuracy with CalOptima's directories.

Physician Group shall provide to CalOptima any information necessary for CalOptima to comply with State Laws. If Physician Group does not comply with this provision or demonstrates a pattern of repeated failure, CalOptima may terminate the Contract. [HSC § 1367.27]

2.5 **Notices to Members of Termination or Block Transfer.** Physician Group shall cooperate and assist CalOptima in fulfilling CalOptima's obligations under 28 CCR § 1300.67.1.3 regarding block transfer filings with the DMHC. Any written communications to Members that concern a termination of this Contract or block transfer shall comply with the notification requirements in HSC § 1373.65(f). CalOptima shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]

2.6 **Continuation of Care after Termination for Certain Conditions.** If the Contract is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Physician Group and Contracted Providers will, at the request of the Member and CalOptima, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of continued services for Members with these medical

conditions is subject to the same contractual terms and conditions that were imposed upon Physician Group prior to termination. Reimbursement for such services will be as agreed between the Parties. Upon termination of the Contract, CalOptima is liable for the Covered Services rendered by Physician Group and its Contracted Providers (other than any permissible co-payments, co-insurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Physician Group's or a Contracted Provider's care at the time of termination of the Contract until the Covered Services that Physician Group or the Contracted Provider is rendering to the Member are completed or until CalOptima makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Provider. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]

2.7 **Quality Assurance Program.** CalOptima will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Physician Group and Contracted Providers will assist CalOptima in maintaining CalOptima's quality assurance program, as applicable, and consistent with CalOptima's quality assurance program policies and procedures. To the extent that any of CalOptima's quality assurance functions are delegated to Physician Group, Physician Group shall promptly deliver to CalOptima all information requested for the purpose of monitoring and evaluating Physician Group and Contracted Providers' performances of those quality assurance functions and so that CalOptima may comply with Laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2(d), 1300.70]

2.8 **No Inducement to Deny Covered Services.** Physician Group acknowledges and agrees that this Contract does ***not*** (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Physician Group to induce Physician Group or its Contracted Providers to provide care to Members in a manner inconsistent with coverage requirements. Physician Group shall ensure that its contracts with Providers similarly comply with this Section 2.8. [HSC §§ 1348.6, 1367.62(a)(3)]

2.9 **Appeals and Grievances of Members.** CalOptima will be responsible for resolving Member Appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. CalOptima's process to resolve provider grievances are set forth in the Contract and the Provider Manual. Physician Group and its Contracted Providers will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Physician Group and Contracted Providers shall cooperate with CalOptima in responding to Member grievances and requests for independent medical reviews consistent with CalOptima's Policies. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a)-(b)]

2.10 **Language Assistance Program Standards.** Physician Group and its Contracted Providers shall comply with the language assistance standards promulgated by the DMHC and with CalOptima's language assistance program and shall cooperate with CalOptima in providing any information necessary to assess compliance. [HSC § 1367.04(f); 28 CCR § 1300.67.04]

2.11 **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Physician Group and Contracted Providers will not invoice or balance bill any Member for the difference between Physician Group or its Contracted Providers' billed charges and the reimbursement paid by CalOptima or its capitated provider for any Covered Service. In addition, in the event CalOptima or its capitated provider, including Physician Group,

fails to pay for Covered Services, Members will not be liable to Physician Group or Providers for any sums owed by CalOptima or its capitated provider, including Physician Group. Physician Group shall not maintain any action at law against a Member to collect sums owed by CalOptima or its capitated provider. [HSC §§ 1379 (a)- (c), 1371.9; 28 CCR § 1300.71(g)(4)]

2.12 **No Surcharges.** Physician Group, its Contracted Providers, and their agents, trustees, or assignees shall not impose or collect a surcharge from a Member for services provided to the Member pursuant to the Contract. Nor shall Physician Group, its Contracted Providers, or their agents, trustees or assignees maintain any action at law against a Member to collect sums owed by CalOptima to Physician Group or Contracted Providers for services provided to the Member pursuant to the Contract. In its agreements with Providers, Physician Group shall (i) prohibit the Provider from imposing or collecting a surcharge from a Member for services provided to the Member pursuant to an agreement between Physician Group and Provider and (ii) prohibit the Provider from maintaining any action at law against a Member to collect sums owed by Physician Group to Provider for services provided to the Member pursuant to an agreement between Physician Group and Provider. Upon notice of any such action or upon notice that Physician Group or its Contracted Providers has imposed surcharges for Covered Services, CalOptima will take appropriate action. As used in this Section II, the term "**surcharges**" means an additional fee that is charged to a Member for a Covered Service, but that is not approved by the Director of the DMHC ("**Director**"). [HSC § 1379 (c); 28 CCR § 1300.67.8(d)]

2.13 **Reporting or Surcharges and Cost-Sharing.** Physician Group will report to CalOptima in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Physician Group or its Contracted Providers. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]

2.14 **Third Party Recoveries.** Physician Group and its Contracted Providers shall cooperate with CalOptima in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Physician Group or its Contracted Providers from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other Laws.

2.15 **Claims for Secondary Payment.** Physician Group will pay Claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. Notwithstanding any other provision in this Contract, if Physician Group is not the primary payer under coordination of benefits, a Provider may submit Claims to Physician Group within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer. Except as otherwise provided by Laws or provided by Government Program Requirements, any Claims that are not submitted by Provider to Physician Group within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer shall not be eligible for payment, and Physician Group and Provider hereby waives any right to payment thereof. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]

2.16 **Good Cause for Late Filing.** If Physician Group denies a Claim because it was filed beyond the Claim filing deadline, CalOptima will, upon a provider's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

2.17 **Authorization of CalOptima's Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment CalOptima makes in future payments to Physician Group, CalOptima shall furnish Physician Group

with a separate written notice of the Overpayment that clearly identifies the overpaid amount, Claim, Member's name, Date(s) of Service, and explains the basis for CalOptima's request for reimbursement of the Overpayment, including any interest and penalties on the Claim. If Physician Group intends to contest CalOptima's notice, Physician Group must send written notice of Physician Group's intent to contest within thirty (30) Business Days of Physician Group's receipt of CalOptima's notice. If CalOptima does not receive a notice of intent to contest notice of the Overpayment or the requested reimbursement from Physician Group within the above timeframes, Physician Group authorizes CalOptima to offset or recoup the requested reimbursement amount from CalOptima's payments to Physician Group for current or future Claim submissions. [28 CCR § 1300.71(d)]

2.18 **Provider Dispute Resolution.** CalOptima shall establish and maintain a provider dispute resolution process to process and resolve any disputes between Physician Group and CalOptima, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Physician Group may obtain specific information regarding CalOptima's provider dispute resolution process in CalOptima's Policies. Physician Group has a right to access CalOptima's provider dispute resolution process. CalOptima will inform Physician Group of any changes to CalOptima's provider dispute resolution procedures. Physician Group will receive the rights listed in HSC § 1375.7, as amended, if CalOptima makes any changes to the provider dispute resolution process. Physician Group may utilize CalOptima's provider dispute resolution process or obtain information about the process by writing to Provider Dispute Resolution Claims at the appropriate address outlined in the Provider Manual or calling (714) 246-8600. The provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1 *et seq*. See the Provider Manual for current information regarding CalOptima's provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h) (1) and (2); 28 CCR §§ 1300.71.38, 1300.71(e)]

2.19 **Member Confidentiality.** Physician Group and its Contracted Providers will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the CMIA, including California Civil Code §§ 56.10, 56.104, and 56.107. Physician Group shall prohibit Contracted Providers from disclosing medical information regarding a Member unless such disclosure complies with the requirements of the CMIA. [HSC §§ 1348.5, 1364.5; 28 CCR §§ 1300.51(d) K.2, 1300.67.8(a)]

2.20 **Maintenance and Access to Records.**

2.20.1 Physician Group will prepare and maintain on a current and accurate basis all records, books, and papers related to this Contract ("**Records**") possessed in any medium. Such Records shall be made available for inspection, including through electronic means, and copying by CalOptima and/or the DMHC, as may be necessary for CalOptima's compliance with the provisions of the Knox-Keene Act and the rules.

2.20.2 Physician Group shall make all Records available in the State of California or furnish true and accurate copies of such Records upon request by CalOptima and/or DMHC.

2.20.3 If CalOptima and/or DMHC requests to inspect Records, Physician Group shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

2.20.4 To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format. Records must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

2.20.5 Physician Group shall cooperate with CalOptima with respect to any DMHC examination of the fiscal and administrative affairs of CalOptima or CalOptima's subcontractors.

2.20.6 Physician Group shall maintain on a current and accurate basis and ensure ready availability of Member Medical Records. Upon CalOptima's request, Physician Group shall make available, at reasonable times, Physician Group's Records relating to the services provided to Members, to the cost thereof, to payments received by Physician Group from Members (or from others on their behalf), and, unless Physician Group is compensated on a fee-for-service basis, to the financial condition of Physician Group. Physician Group will permit CalOptima to examine its Contracted Provider contracts solely as required by the DMHC to determine compliance with the Knox-Keene Act and rules.

2.20.7 The obligation under this Section 2.20 shall survive termination of the Contract for any reason.

[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

2.21 **Amendments.** The Provider Manual may be unilaterally amended or modified by CalOptima to maintain consistency or compliance with Laws, CalOptima Policies, directives, Government Program Requirements, or requirements of an Accreditation Organization upon forty-five (45) Business Days' notice to Physician Group unless a shorter timeframe is necessary for compliance. CalOptima may otherwise materially amend the Provider Manual only after forty-five (45) Business Days' prior written notice to Physician Group. If Physician Group does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Physician Group. If CalOptima receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Physician Group has the right to terminate this Contract prior to the effective date of the amendment or modification. [HSC § 1375.7; 28 CCR § 1300.71(m)]

2.22 **Compliance with Laws.** CalOptima is subject to Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Contract shall bind the Parties whether or not expressly set forth in this Contract. Physician Group shall comply with Chapter 2.2 of Division 2 of the HSC and Chapter 2 of Title 28 CCR to the extent applicable to the Physician Group.

2.23 **Quality and Utilization.** CalOptima will disclose to Physician Group CalOptima's QI or utilization management programs and procedures at least fifteen (15) Business Days prior to Physician Group executing this Contract. A change to the QI or utilization management programs or procedures shall be made pursuant to Section 2.21. Notwithstanding the foregoing, CalOptima may make a change to the QI or UM Programs or procedures at any time if the change is necessary to comply with Laws or any accreditation requirements of

a private sector Accreditation Organization. [HSC § 1375.7(b)(3)]

2.24 **Data Usage.** The provisions of this section will apply only to the extent that Physician Group or a Provider, now or in the future, acts as a "**Service Provider**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code §§ 1798.100 *et seq*., 1798.140(v), and the regulations promulgated thereunder). Physician Group warrants and represents that all Personal Information (as defined below) shall not be: (i) retained, used, or disclosed by Physician Group for any purpose other than for the specific purpose of performing the services specified in the Contract; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Physician Group shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Contract or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140 (t)(1). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140 (o).

2.25 **Health Care Providers' Bill of Rights.** Physician Group is entitled to all protections afforded to Physician Group under the Health Care Providers' Bill of Rights. [HSC § 1375.7]

2.26 **Telehealth Services.** Physician Group shall require Providers that use telehealth for rendering Covered Services to obtain and document Member consent prior to providing telehealth services, as required under Business and Professions Code § 2290.5. As required by HSC § 1374.14, Physician Group shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately delivered through telehealth services on the same basis and to the same extent that Physician Group is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or Behavioral Health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. As delegated, Physician Group shall comply with all requirements of HSC §§ 1374.14 and 1374.141, including obtaining Member consent for use of telehealth services and complying with records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]

2.27 **Liabilities.** CalOptima and Physician Group are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Contract is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part CalOptima or Physician Group based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]

2.28 **Reporting**. Physician Group agrees to submit all information or reports required under this Contract or requested by CalOptima or DMHC to comply with Laws in a form acceptable to CalOptima or DMHC.

2.29 **Deductible and Out-of-Pocket Accrual Balances**. If CalOptima delegates Claims payment functions to Physician Group, Physician Group shall comply with Laws, including the requirements of HSC § 1367.0061 for calculating and reporting a Member's accrual towards their annual deductible, if any, and annual out-of-pocket maximum for covered benefits, and with CalOptima's monitoring and reporting requirements. [HSC § 1367.0061]

2.30 **Mental Health Parity Requirements**. Physician Group shall comply with applicable Laws and CalOptima Policies on the provision of Medically Necessary Treatment of Mental Health and Substance Use Disorder, as defined by HSC § 1374.72(a) ("**MH/SUD Services**"). Physician Group shall adopt and use CalOptima Policies when providing MH/SUD Services or, if Physician Group establishes its own policies, Physician Group will obtain CalOptima's prior written approval and shall ensure that the policies include requirements for:

2.30.1 Ensuring that (i) MH/SUD Services are provided within applicable geographic and timely access standards, or arranging for coverage with an out-of-network provider if services are not available in network, and, as necessary, follow-up services that, to the maximum extent possible, meet applicable geographic and timely access standards; (ii) that notices for out-of-network MH/SUD Services are provided as required by 28 CCR § 1300.74.72; and (iii) that a Member's SOC is no greater than the Member's SOC if the MH/SUD Services were provided by an in-network provider. [HSC § 1374.72(d); 28 CCR § 1300.74.72]

2.30.2 Conducting Medical Necessity determinations and/or utilization reviews in compliance with CalOptima Policies, HSC § 1374.721, and 28 CCR § 1300.74.721, including using the most recent criteria and clinical guidelines developed by the nonprofit professional association for the relevant clinical specialty ("**MH/SUD Non-Profit Criteria**").

2.30.3 Complying with all applicable requirements for training, education programs, availability of MH/SUD Non-Profit Criteria to Providers or Members, analysis of how the MH/SUD Non-Profit Criteria is applied, and interrater reliability testing, as detailed in HSC § 1374.721(e) and 28 CCR § 1300.74.721(o), to ensure proper use of the MH/SUD Non-Profit Criteria.

III. DMHC Risk Bearing Organization Requirements

3.1 **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Section III.

3.1.1 **Cash-to-Claims Ratio** means the Organization's cash, readily available marketable securities and HMO capitation receivables due within thirty (30) days, divided by the Organization's unpaid Claims (Claims payable and incurred but not reported ("**IBNR**")) liability. Organization shall report only those HMO capitation receivables due within thirty (30) days and that the Organization reasonably believes will be received by that time.

3.1.2 **Corrective Action Plan** ("**CAP**") means a plan reflected in a document containing requirements for correcting and monitoring Organization's efforts to correct any financial solvency deficiencies in the Grading Criteria, or other financial or Claims payment deficiencies, determined through the DMHC's review or audit process, indicating that Organization may lack the capacity to meets its contractual obligations consistent with the requirements of 28 CCR § 1300.70(b)(2)(H)(1).

3.1.3 **External Party** means the DMHC or its designated agent, which may be contracted or appointed to fulfill the functions stated in the Solvency Regulations. Whenever the Solvency Regulations or this Section III reference the DMHC, it shall mean the DMHC or its designated agent.

3.1.4 **Grading Criteria** means the four grading/reviewing criteria specified in HSC § 1375.4(b)(1)(A)(i)-(iv) and the Cash-to-Claims Ratio as defined above.

3.1.5 **Organization** means a risk-bearing organization as defined in HSC § 1375.4(g). An Organization includes an entity that contracts directly with Physician Group or subcontracts with another Organization to arrange for the health care services of CalOptima's Members and meets the requirements of HSC § 1375.4(g).

3.1.6 **Risk Arrangement** means both a "**Risk-Sharing Arrangement**" and "**Risk-Shifting Arrangement**," which are defined as follows:

3.1.6.1 **Risk-Sharing Arrangement** means any compensation arrangement between an Organization and CalOptima under which the Organization shares the risk of financial gain or loss with CalOptima.

3.1.6.2 **Risk-Shifting Arrangement** means a contractual arrangement between an Organization and CalOptima under which CalOptima pays the Organization on a fixed, periodic or Capitated Basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the Organization.

3.1.7 **Sub-Delegating Organization** means an Organization that delegates any portion of the responsibility for providing or arranging for the health care services of CalOptima's Members to another Organization on a capitated or fixed period payment basis.

3.2 **Risk Arrangement Requirements.**

3.2.1 **Risk Arrangement Disclosures and Reporting.** CalOptima, under this Contract, and Physician Group, if it is acting as a Sub-Delegating Organization under any other contract that involves a Risk Arrangement between Physician Group and an Organization, shall comply with the disclosure and reporting requirements in 28 CCR §§ 1300.75.4.1, 1300.75.4.3.

3.2.2 **Organization Information.** Physician Group, under this Contract, and any Organization under a Risk Arrangement with Physician Group where Physician Group is acting as a Sub-Delegating Organization, shall comply with the requirements in 28 CCR § 1300.75.4.2, including the minimum Cash-to-Claims Ratio, quarterly reporting, and notification requirements.

3.2.3 **Non-Compliance is Material Breach.** CalOptima and Physician Group, if it is acting as a Sub-Delegating Organization, shall comply with and shall have adequate procedures in place to comply with the requirements of 28 CCR **§ 1300.75.4.5.** Physician Group's failure to substantially comply with the contractual requirements required by the Solvency Regulations shall constitute a material breach of the Contract. Neither CalOptima nor Physician Group acting as a Sub-Delegating Organization shall request or accept a waiver of any contractual requirements set forth in these Solvency Regulations.

3.3 **Organization Evaluation.**

3.3.1 Physician Group shall comply with the DMHC's review and audit process, in determining Physician Group's satisfaction of the Grading Criteria;

3.3.2 Physician Group shall permit the DMHC to perform any of the following activities in conjunction with CalOptima's oversight process: obtain and evaluate supplemental financial information pertaining to Physician Group when: (i) Physician Group fails to satisfactorily demonstrate its compliance with the Grading Criteria; (ii) Physician Group experiences an event that materially alters its ability

to remain compliant with the Grading Criteria; (iii) the External Party's review or audit process indicates that Physician Group may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of 28 CCR § 1300.70(b)(2)(H)(1); or (iv) DMHC receives information from complaints submitted to the HMO Help Center, health plan reporting, medical audits and surveys or any other source that indicates the Organization may be delaying referrals or Authorizations or failing to meet access standards for basic health care services based on financial considerations; and

3.3.3 Physician Group shall include these requirements in Section 3.9 in any Risk Arrangement it has with another Organization where Physician Group is acting as a Sub-Delegating Organization.

3.4 **Corrective Action Plans.** Physician Group and CalOptima shall comply with the processes set forth in the Solvency Regulations and administered by the DMHC, including the procedures and requirements in 28 CCR § 1300.75.4.8, for the development and implementation of CAPs under this Contract and any contract where Physician Group is acting as a Sub-Delegating Organization.

ATTACHMENT E

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

0348-0046

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report
4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:		Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:		9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)		b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)

Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("**Agreement**") is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima ("**CalOptima**"), and _____, a _____ ("**Business Associate**"), effective _____ ("**Effective Date**"). CalOptima and Business Associate are each a "**Party**" to this Agreement and are collectively referred to as the "**Parties**."

RECITALS

WHEREAS, the Parties have executed an agreement(s) whereby Business Associate provides services to CalOptima, and Business Associate creates, receives, maintains, uses, or transmits protected health information ("**PHI**") in order to provide those services ("**Services Agreement(s)**");

WHEREAS, as a covered entity, CalOptima is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("**HIPAA**") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations ("**C.F.R.**") Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("**Privacy Regulations**") and the Security Standards for Electronic Protected Health Information ("**Security Regulations**") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Business Associate is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the Parties agree as follows:

1. **Definitions**. The terms in this section and otherwise defined in this Business Associate Agreement shall have the definitions set forth below for purposes of this Business Associate Agreement. Terms used, but not otherwise defined, in this Business Associate Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, the regulations promulgated thereunder, and the Services Agreement.

    1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

    1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, Use, or Disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential Information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data Aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated Record Set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **Disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic Health Record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic Media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including transmissions of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic Protected Health Information** ("**ePHI**") means Individually Identifiable Health Information, including PHI, that is transmitted by or maintained in Electronic Media.

1.11. **Health Care Operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually Identifiable Health Information** means health information, including demographic information collected from an Individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, that identifies the Individual or where there is a reasonable basis to believe the information can be used to identify the Individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information System** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected Health Information** ("**PHI**"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and medical information as defined in the California Confidentiality of Medical Information Act at California Civil Code § 56.05(j) ("**CMIA**"). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Reproductive Health Care** means health care, as defined at 45 C.F.R. § 160.103, that affects the health of an Individual in all matters relating to the reproductive system and to its functions and processes.

1.17. **Required by Law** means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.18. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.19. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

1.20. **Services** has the same meaning as in the Services Agreement(s).

1.21. **Unsecured Protected Health Information** ("**Unsecured PHI**") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.22. **Use** and **Uses** mean, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima intends that Business Associate may create, receive, maintain, transmit, or aggregate certain information pursuant to the terms of this Agreement, some of which may constitute PHI protected by federal and/or state laws.

3. Business Associate is the business associate of CalOptima acting on CalOptima's behalf and provides services or arranges, performs, or assists in the performance of functions or activities on behalf of or to CalOptima, and may create, receive, maintain, transmit, aggregate, Use, or Disclose PHI in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may Use or Disclose PHI, only to perform functions, activities or services specified in this Agreement on behalf of or for CalOptima, provided that such Use or Disclosure would not violate HIPAA, including the Privacy Regulations, or other applicable laws if done by CalOptima.

4.1. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may Use and Disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may Disclose PHI for this purpose if the Disclosure is Required by Law, or the Business Associate obtains reasonable assurances, in writing, from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

4.2. **Data Aggregation**. If authorized as part of the Services provided to CalOptima under the Services Agreement, Business Associate may Use PHI to provide Data Aggregation services relating to the Health Care Operations of CalOptima.

5. **Prohibited Uses and Disclosures of PHI**

5.1. **Restrictions on Certain Disclosures to Health Plans**. Business Associate shall not Disclose PHI about an Individual to a health plan for payment or Health Care Operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section 5.1, only refers to PHI as defined in 45 C.F.R. § 160.103.

5.2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima and CalOptima's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section 5.2, only refers to PHI as defined in 45 C.F.R. § 160.103.

5.3. **Prohibition of Disclosure of PHI Related to Reproductive Health Care**. Business Associate shall comply with 45 C.F.R. Part 164, Subpart E regarding Uses and Disclosures of Reproductive Health Care-related information, including the following:

5.3.1. Business Associate shall comply with requirements of 45 C.F.R. § 164.502(a)(5)(iii) and shall not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; or (iii) to identify any person for any purpose previously described (each a

"**Prohibited Purpose**").

5.3.2. To the extent applicable, if Business Associate receives a request for Reproductive Health Care-related information for a non-Prohibited Purpose that is otherwise permissible under HIPAA, HITECH, the Privacy Regulations, and the Security Regulations, Business Associate shall obtain a valid attestation under 45 C.F.R. § 164.509 if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under 45 C.F.R. § 164.512(d); (ii) judicial or administrative proceedings under 45 C.F.R. § 164.512(e); (iii) Disclosures for law enforcement purposes under 45 C.F.R. § 164.512(f); or (iv) Disclosures about decedents to coroners and medical examiners under 45 C.F.R. § 164.512(g)(1).

6. Compliance with Other Applicable Laws

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

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

6.1.2. To treat any violation of such additional and/or more protective standards as a Breach or Security Incident, as appropriate, pursuant to Section 16 of this Agreement.

6.2. Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or Confidential Information, as defined in Section 1.4 of this Agreement, include, but are not limited to the CMIA, the Information Practices Act at California Civil Code § 1798 *et seq.*, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and California Health and Safety Code § 11845.5. Business Associate shall ensure that any Medical Information related to Sensitive Services (as those terms are defined under Civil Code § 56.05) received or accessed under the Agreement is kept confidential, segregated, and only disclosed, accessed, transferred, transmitted, or processed in accordance with CMIA requirements, including Civil Code §§ 56.10, 56.11, 56.107, 56.108, and 56.110, as applicable.

7. Additional Responsibilities of Business Associate

7.1. **Nondisclosure**. Business Associate shall not Use or Disclose PHI or other Confidential Information other than as permitted or required by this Agreement or as Required by Law.

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use appropriate safeguards to prevent the Use or Disclosure of PHI other than as provided by the Agreement. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality,

integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of CalOptima, and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent Use or Disclosure of the information other than as provided for by this Agreement.

7.2.2. Business Associate agrees to take reasonable steps, including providing adequate training to its employees, to ensure compliance with this Agreement and to ensure that the actions or omissions of its employees or agents do not cause Business Associate to breach the terms of this Agreement.

7.2.3. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

7.2.4. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other Confidential Information. Without limiting the foregoing, Business Associate shall maintain, at a minimum, the most current industry standards, for encryption of all workstations, laptops, and removable media devices containing PHI and data transmission and storage of PHI, unless Business Associate complies with applicable requirements of the Security Regulations, including 45 C.F.R. §§ 164.306 and 164.312.

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

7.2.6. Business Associate shall ensure that all members of its workforce with access to PHI and/or other Confidential Information are trained at least annually on the Privacy and Security Requirements and comply with the terms of this Agreement.

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

7.3. **Minimum Necessary**. With respect to any permitted Use, Disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **Business Associate's Agent**. Business Associate shall ensure that any agents, subcontractors, vendors, or others (collectively, "**Agents**") that create, maintain, receive, transmit, Use, or Disclose PHI on behalf of Business Associate agree through a written agreement to comply with applicable requirements of the Privacy and Security Rules, and with the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI.

8. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI and other Confidential Information in violation of the requirements of this Agreement.

9. **Access to PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) days after receipt of request from CalOptima. If Business Associate maintains an Electronic Health Record with PHI and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524.

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526, as requested by CalOptima in the time and manner designated by CalOptima.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima or (at the direction of CalOptima) to an Individual such Disclosures of PHI and information related to such Disclosures as necessary to respond to a proper request by the subject Individual for an accounting of Disclosures of PHI in accordance with HIPAA, the HITECH Act, and implementing regulations, including 45 C.F.R. § 164.528. Unless directed by CalOptima to make available to an Individual, Business Associate shall provide to CalOptima, within thirty (30) days after receipt of request from CalOptima, information collected in accordance with this Section 11 to permit CalOptima to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

    11.1. The date of the Disclosure;

    11.2. The name, and address if known, of the entity or person who received the PHI;

    11.3. A brief description of the PHI disclosed; and

    11.4. A brief statement of the purpose of the Disclosure.

    For each Disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima**. To the extent Business Associate is to carry out an obligation of CalOptima under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart E that apply to CalOptima in the performance of such obligation.

14. **Access to Practices, Books and Records**. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI on behalf of CalOptima available to CalOptima, the Secretary, and other Regulators for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, CMIA, and implementing regulations. Business Associate shall immediately notify CalOptima of any requests made by the Secretary, other Regulators, and provide CalOptima with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima or, if agreed to by CalOptima, destroy all PHI and other Confidential Information received from, or created or received by Business Associate on behalf of, CalOptima that Business Associate or its Agents still maintains in any form, and shall retain no copies of such information. If CalOptima elects destruction of PHI and/or other Confidential Information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15.1 and 15.2 below and shall certify in writing to CalOptima that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima of the conditions that make the return or destruction infeasible. If such return or destruction is not feasible, CalOptima shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

15.1. **Data Destruction**. Data destruction methods for CalOptima PHI or Confidential Information must conform to the NIST Special Publication 800-88. Other methods require prior written permission of CalOptima and, if necessary, CalOptima's regulator(s).

15.2. **Destruction of Hard Copy Confidential Data**. CalOptima PHI or Confidential Information in hard copy form must be disposed of through confidential means, such as crosscut shredding and pulverizing.

16. **Breaches and Security Incidents**. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any Use or Disclosure of PHI not permitted by the Agreement of which it becomes aware of, including a Breach or Security Incident, and take the following steps:

16.1. **Notice to CalOptima.**

16.1.1. Business Associate shall notify CalOptima within [five (5)] days by email (or by telephone if Business Associate is unable to email CalOptima) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

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

16.1.1.2. Any suspected Security Incident which risks unauthorized access to PHI and/or other Confidential Information;

16.1.1.3. Any intrusion or unauthorized access, Use or Disclosure of PHI in violation of this Agreement; or

16.1.1.4. Potential loss of confidential data affecting this Agreement.

16.1.2. Notice shall be provided to the CalOptima Privacy Officer ("**CalOptima Contact**") using the CalOptima Contact Information at Section 16.7 below. Such notification by Business Associate shall comply with CalOptima's form and content requirements for reporting a privacy incident and shall include all information known at the time the incident is reported.

16.1.3. Notice under this Section 16.1 is deemed given to CalOptima for Unsuccessful Attempts, and no further notice of such Unsuccessful Attempts is required for Business Associate. For purposes of this section, "**Unsuccessful Attempts**" means pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, as long as no such incident results in unauthorized access, acquisition, Use, or Disclosure of PHI and/or other Confidential Information.

16.2. **Required Actions**. Upon discovery of a Breach or suspected Security Incident, intrusion or unauthorized access, Use or Disclosure of PHI, Business Associate shall take:

16.2.1. Prompt action to mitigate any risks or damages involved with the Security Incident or Breach;

16.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

16.2.3. Any corrective actions required by CalOptima or CalOptima's regulator(s).

16.3. **Investigation**. Business Associate shall immediately investigate such Security Incident or Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting such privacy incident. Such report shall include the following:

16.3.1. Incident details, including the date of the incident and when it was discovered;

16.3.2. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;

16.3.3. The nature of the data elements involved and the extent of the data involved in the Breach;

16.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

16.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

16.3.6. A description of the probable causes of the improper Use or Disclosure;

16.3.7. Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);

16.3.8. Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured PHI;

16.3.9. Whether a law enforcement official has requested a delay in notification of Individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or Confidential Information because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

16.3.10. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

16.4. **Complete Report**. Business Associate shall provide a complete written report of the investigation ("**Final Report**") to the CalOptima Contact within [fifteen (15)] days of the discovery of the Security Incident or Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting of such privacy incident.

16.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 16.3 above and the following:

16.4.1.1. An assessment of all known factors relevant to a determination of whether a Breach occurred under HIPAA and other applicable federal and state laws;

16.4.1.2. A full, detailed corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future, including its implementation date and information on mitigation measures taken to halt and/or contain the improper Use or Disclosure and to reduce the harmful effects of the Breach. All corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s), as applicable; and

16.4.1.3. The potential impacts of the incident, such as potential misuse of data and identity theft.

16.4.2. If CalOptima or CalOptima's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

16.4.3. CalOptima and CalOptima's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a Breach occurred, whether the Security Incident or Breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

16.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final

Report within the [fifteen (15)] day timeframe specified in Section 16.4 above, Business Associate shall request approval from CalOptima within the [fifteen (15)] day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima and, if necessary, CalOptima's regulator(s).

16.5. **Notification of Individuals**. If the cause of a Breach is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify Individuals accordingly and pay all costs of such notifications, as well as costs associated with the Breach. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with CalOptima. CalOptima and CalOptima regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima and CalOptima regulator(s), as applicable, must be obtained before the notifications are made.

16.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima**. If the cause of a Breach of PHI is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate agrees that CalOptima shall make all required reporting of the Breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

16.7. **CalOptima Contact Information**. To direct communications to the CalOptima Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

CalOptima Privacy Office

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

17. **Responsibilities of CalOptima**. CalOptima agrees to not request the Business Associate to Use or Disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

18. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima for and hold it harmless from (i) any and all fees and expenses CalOptima incurs in investigating, responding to, and/or mitigating a Breach of PHI or Confidential Information caused by Business Associate or its Agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima due to a claim, lawsuit, or demand by a third party arising out of a Breach of PHI or

Confidential Information caused by Business Associate or its Agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima by any government agency/regulator based on a Breach of PHI or Confidential Information caused by Business Associate or its Agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of Breach to Individuals and regulators, and required reporting of Breach. Acceptance by CalOptima of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

19. **Audits, Inspection, and Enforcement**

19.1. From time to time, CalOptima and/or CalOptima's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the CalOptima Privacy Officer in writing. Whether or how CalOptima or CalOptima's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

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

20. **Term and Termination**

[For Standalone Agreement]

20.1. **Term.** The term of this Agreement shall be effective as of the Effective Date and shall terminate either (i) in accordance with this Section 20 or (ii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima in accordance with Section 15. CalOptima may terminate this Agreement, without cause, on five (5) days' prior written notice to Business Associate.

[Alternate Provision for Agreement as an exhibit to an agreement]

20.1 **Term**. This exhibit is effective as of the Effective Date and shall terminate when (i) the Services Agreement terminates, (ii) in accordance with this Section 20, or (iii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with Section 15.

20.2. **Termination for Cause**. If CalOptima determines that Business Associate has violated a material term of this Agreement, CalOptima may in its discretion:

20.2.1. Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time

specified by CalOptima; or

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

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

21. Miscellaneous Provisions

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

21.2. **Amendment**

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

21.2.2. In addition to automatic amendments under Section 21.2.1, CalOptima reserves the right to amend the Agreement at any time when such modifications are necessary to comply with changes in (i) applicable laws, (ii) CalOptima's contracts with government regulators, or (iii) in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall promptly notify Business Associate in writing of such Regulatory Changes in accordance with applicable federal and/or State requirements, and Business Associate shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a CalOptima government regulator.

21.2.3. Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 21.2.1 or 21.2.2 shall constitute a material violation of this Agreement.

21.3. **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and Agents available to CalOptima or CalOptima's regulator(s) at no cost to CalOptima or CalOptima's regulator(s), as applicable, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CalOptima or CalOptima's regulator(s), their respective directors, officers and/or employees based upon a claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

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

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

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

21.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

21.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or Confidential Information by Business Associate or any agent, subcontractor, employee or third party that received PHI or Confidential Information, and Business Associate agrees that CalOptima may seek injunctive relief under this section without any requirement to prove actual monetary damage or post a bond or other security.

21.9. **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of CalOptima's contracts with regulator(s) or any other monitoring requests by CalOptima's regulator(s).

21.10. **Data Ownership**. Business Associate's data stewardship does not confer data ownership rights on Business Associate with respect to any PHI or Confidential Information shared under the Agreement.

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima, this Business Associate Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate	CalOptima
_____	_____
Print Name	Print Name
_____	_____
Signature	Signature
_____	_____
Title	Title
_____	_____
Date	Date

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participation**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**MSSP**
[Y/N]	**PACE**
[Y/N]	**Covered California**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 There are no additional defined terms.

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are those items and services defined under an applicable Program and CalOptima Policies, required to be furnished to Members by Provider under this Contract (as further detailed in this Attachment A), and, as applicable, Authorized (with the exception of Emergency Services), including: [*add specific Covered Services description*]

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Days to Appointment**. Provider shall offer appointments for Covered Services in accordance with Laws, including Covered Services that are not Emergency Services or urgent care services within the following time frames after a Member's request: (i) ten (10) Business Days for PCPs, (ii) fifteen (15) Business Days for specialist physicians; and (iii) ten (10) Business Days for non-urgent, non-physician mental health or substance use disorder Covered Services; provided, however, preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. If Provider supplies maternity Covered Services, Provider shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Provider shall also have a process in place for follow-up on Member missed appointments.

4.2 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.3 **Health Education and Prevention**. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima's health education referral line for classes provided to Members.

4.4 **Coordination of Care**. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member needs, monitoring progress of Members' care, and coordinating utilization of services with Member's PCP.

4.5 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.6 **COD-Administrative Members**. Provider shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be defined in CalOptima Policies, as well as Article 3 of this Attachment A. In the event of a conflict between CalOptima Policies and Article 3, CalOptima Policies shall control with respect to COD-Administrative Members.

4.7 **Model of Care**. Provider shall comply with CalOptima's model of care, as specified for the Program.

4.8 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.9 **Interdisciplinary Care**. Provider shall participate with CalOptima's Interdisciplinary Care Team and contribute to the Individualized Care Plan for each Member in accordance with CalOptima Policies and the applicable Program requirements.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least $1,000,000 per incident/$3,000,000 aggregate per year. CalOptima is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against CalOptima are to be waived.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.1 Commercial General Liability of $1,000,000 per incident/$2,000,000 aggregate per year.

5.2.2 Commercial Crime Liability of $250,000 aggregate per year.

5.2.3 Automobile Liability of $500,000 combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ATTACHMENT B
COMPENSATION

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws, and Provider shall accept as payment in full from CalOptima for services provided under this Contract the amounts set forth in this Attachment B.

2. **Payment**.

2.1 Medi-Cal.

2.1.1 For Covered Services provided to Medi-Cal Members, CalOptima shall reimburse Provider as follows:

2.1.1.1 **@@Custom Field{Anc Mcal PCT Amt}@@% of the CalOptima Medi-Cal Fee Schedule**, as defined in CalOptima Policies, in effect for the date of service.

2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, Provider will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, Laws, and CalOptima Policies.

2.1.3 *Claims Requirements.* Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medi-Cal billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal Fee Schedule at the time of service are not reimbursable under this Contract.

2.1.3.1 Report Codes shall be billed and paid according to Medi-Cal rules and guidelines.

2.2 OneCare.

2.2.1 For Covered Services provided to OneCare Members, CalOptima shall reimburse Provider as follows:

2.2.1.1 **@@Custom Field{Anc McAdv PCT Amt}@@ %** of the Medicare Allowable Fee Schedule in effect for the date of service.

2.2.2 *Claims Requirement.* Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules, guidelines, and payment policies. Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.5.

2.2.2.1 Report Codes shall be billed and paid according to Medicare rules and guidelines.

2.3 PACE.

2.3.1 For Covered Services provided to PACE Members, CalOptima shall reimburse Provider as follows:

2.3.1.1 **@@Custom Field{Anc PACE PCT Amt}@@%** of the Medicare Allowable Fee Schedule in effect for the date of service.

2.3.2 Claims Requirements. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules, guidelines, and payment policies. Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.5.

2.3.2.1 Report Codes shall be billed and paid according to Medicare rules and guidelines.

2.4 Covered California.

2.4.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.4.1.1 [INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

2.5 Services with Unestablished Fees. If a fee has not been established by Medi-Cal or Medicare for a particular procedure and CalOptima has provided Authorization for Provider to provide such service, CalOptima shall reimburse Provider under the following guidelines:

2.5.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services will be paid at [Percent] of Provider's full billed charges and must follow applicable Medi-Cal and Medicare billing rules and guidelines. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Provider shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely

responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

3.8 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or PACE, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

3.9 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18)

years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent.

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participation**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**MSSP**
[Y/N]	**PACE**
[Y/N]	**Covered California**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 There are no additional defined terms.

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are limited to the following: [*add specific Covered Services description*]

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.2 **Health Education and Prevention**. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima's health education referral line for classes provided to Members.

4.3 **Coordination of Care**. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member needs, monitoring progress of Members' care, and coordinating utilization of services with Member's PCP.

4.4 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.5 **COD-Administrative Members**. Provider shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be defined in CalOptima Policies, as well as Article 3 of this Attachment A. In the event of a conflict between CalOptima Policies

and this Article 3, CalOptima Policies shall control with respect to COD-Administrative Members.

4.6 **Model of Care**. Provider shall comply with CalOptima's model of care, as specified for the Program.

4.7 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.8 **Interdisciplinary Care**. Provider shall participate with CalOptima's Interdisciplinary Care Team and contribute to the Individualized Care Plan for each Member in accordance with CalOptima Policies and the applicable Program requirements.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least $1,000,000 per incident/$3,000,000 aggregate per year. CalOptima is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against CalOptima are to be waived.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.1 Commercial General Liability of $1,000,000 per incident/$2,000,000 aggregate per year.

5.2.2 Commercial Crime Liability of $250,000 aggregate per year.

5.2.3 Automobile Liability of $500,000 combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ATTACHMENT B
COMPENSATION

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws, and Provider shall accept as payment in full from CalOptima for services provided under this Contract the amounts set forth in this Attachment B.

2. **Payment**.

2.1 Medi-Cal.

2.1.1 For Medi-Cal Members, CalOptima shall reimburse Provider for Covered Services at **@@Custom Field{Anc Mcal PCT Amt}@@%** of the CalOptima Medi-Cal Fee Schedule, as defined in CalOptima Policies, in effect for the date of services.

2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, Provider will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Medi-Cal Program requirements, Laws, and CalOptima Policies.

2.1.3 *Claims Requirements.* Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medi-Cal billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal Fee Schedule at the time of service are not reimbursable under this Contract.

2.2 OneCare.

2.2.1 For OneCare Members, CalOptima shall reimburse Provider for Covered Services at **@@Custom Field{Anc McAdv PCT Amt}@@ %** of the Medicare Allowable Fee Schedule in effect for the date of service.

2.2.2 *Claims Requirements.* Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules, guidelines, and payment policies. Services not contained in the Medicare Allowable Fee Schedule at the time of service are not reimbursable under this Contract.

2.3 PACE.

2.3.1 For PACE Members, CalOptima shall reimburse Provider for Covered Services at **@@Custom Field{Anc PACE PCT Amt}@@%** of the Medicare Allowable Fee Schedule Sin effect for the date of service.

2.3.2 *Claims Requirements.* Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules,

guidelines, and payment policies. Services not contained in the Medicare Allowable Fee Schedule at the time of service are not reimbursable under this Contract.

2.4 MSSP.

2.4.1 For MSSP Members, CalOptima shall reimburse Provider for Covered Services as follows:

HCPCS Code	Type of Service	Unit Type	Unit Rate

2.4.2 *Claims Requirements.* Upon receipt of Clean Claim, CalOptima shall pay Provider within thirty (30) days for services Authorized the previous month. CalOptima shall not pay Provider for time required for Provider to travel to or from the Member's home, unless travel is included as part of the Authorized services provided, *e.g.* shopping or transportation/escort. In such instances, Provider may also request reimbursement for mileage at the current CalOptima reimbursement rate. Provider shall submit to CalOptima each month an invoice referencing a Service Authorization Form (SAF) number for Authorized services provided the prior month. Invoices are due within fifteen (15) days after the end of the month in which Provider provided the Authorized services.

2.5 Covered California.

2.5.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.5.1.1 [INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Provider shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal or Medicare, as applicable, when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal or Medicare fee schedule, as applicable, at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

3.8 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or Pace, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

3.9 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages

nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent.

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participating**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**PACE**
[Y/N]	**Covered California**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 "**Behavioral Health Services**" means the mental health and substance use disorder services provided through the Mental Health Plan or CalOptima and/or their Subcontractors.

2.1.2 "**CHDP**" means the State's Child Health and Disability Prevention program, as defined in the Health and Safety Code § 12402.5 *et seq*., that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. CHDP services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics ("**AAP**").

2.1.3 "**Emergency Medical Condition**" a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

2.1.4 "**Family Planning**" means Covered Services provided to Members of childbearing age to enable them to determine the number and spacing of their children and to help reduce maternal and infant deaths and diseases by promoting the health and education of potential parents, including (i) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; (ii) laboratory and radiology procedures, drugs, and devices prescribed by a licensed physician and/or associated with Family Planning procedures; (iii) patient visits for the purpose of Family Planning; (iv) Family Planning counseling services provided during a regular patient visit; (v) tubal ligations; (vi) vasectomies; (vii) contraceptive drugs or devices; and (viii) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

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2.1.5 "**HRA**" means the health risk assessment tool that identifies a Member's primary, acute, long-term supports and services, behavioral health and functional needs.

2.1.6 "**ICP**" means the individualized care plan developed by a Member, their ICT, and/or CalOptima.

2.1.7 "**ICT**" means CalOptima's interdisciplinary care team comprised of the primary care provider and care coordinator and other providers at the discretion of the Member who work with the Member to develop, implement and maintain the ICP.

2.1.8 "**Medi-Cal Specialty Mental Health Services**" means the services specified in 9 CCR § 1810.247 provided through an MHP (not including the Medi-Cal managed care Behavioral Health Services specified in Welfare & Institutions Code § 14132.03 and required to be provided by CalOptima).

2.1.9 "**MHP**" means the mental health plan contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for Medi-Cal beneficiaries in Orange County, California.

2.1.10 "**Outpatient Mental Health Services**" means outpatient mental health services for Members with mild to moderate mental health conditions, including individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

2.1.11 "**Pediatric Preventive Services**" means child services that incorporate CHDP and the AAP guidelines for health supervision.

2.1.12 "**SBIRT**" means the screening, brief intervention, and referral to treatment services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

2.1.13 "**Sensitive Services**" means those services related to Family Planning, sexually transmitted disease, abortion, and human immunodeficiency virus testing.

2.1.14 "**Specialist**" means a Participating Provider licensed by the State to practice in the designated specialty.

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are the primary care physician ("**PCP**") services covered under the Member's respective Program, including health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of illnesses within Provider's normal scope of practice (collectively "**PCP Services**"). PCP Services

include the following:[1]

3.1.1 For each Member, all diagnostic and therapeutic professional services; laboratory and other diagnostic tests and procedures; and supplies, drugs, and inoculations customarily provided on an outpatient basis by and within the competence of a PCP, including:

3.1.1.1 Periodic evaluation of all body systems and preventive services, and acute and chronic care.

3.1.1.2 Definitive diagnoses and treatment.

3.1.1.3 Post-treatment and referrals follow-up.

3.1.1.4 Treatment that considers the Member as a whole, considering medical, psychological, social, and emotional issues

3.1.1.5 Preventive medicine, including periodic physical examinations, immunizations, vaccines, and diagnostic tests.

3.1.1.6 "On call", twenty-four (24)-hour accessibility.

3.1.2 Specific PCP Services. PCP Services include the following:

3.1.2.1 Routine office laboratory microscopy.

3.1.2.2 First contact care for persons with previously undifferentiated health concerns.

3.1.2.3 Office visits and examinations (diagnosis and treatment of illness and injury).

3.1.2.4 Adult and pediatric health maintenance.

3.1.2.5 Specimen collection.

3.1.2.6 Nutritional counseling.

3.1.2.7 Interpretation of laboratory results.

3.1.2.8 Miscellaneous supplies related to treatment in Provider's office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies).

3.1.2.9 Telephone consultations.

3.1.2.10 Family planning.

3.1.2.11 Minor surgery (e.g., lacerations)

3.1.2.12 Pregnancy tests.

[1] These listed services are based on routine uncomplicated cases where care is ordinarily provided by a PCP. This list provides guidelines and is not intended to be all inclusive. Provider should use this list with clinical discretion.

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3.1.2.13 Urinalysis.

3.1.2.14 In-office injections of medical or pharmaceutical agents.

3.1.2.15 Twenty-four hours a day, seven days a week on-call coverage.

3.1.2.16 In-office electrocardiograms (EKGs).

3.1.2.17 In-office inhalation treatments.

3.1.2.18 Well woman exams under ICD diagnosis codes X12.4 or Z01.42.

3.1.2.19 Vaccines, and immunizations excluding vaccines for children.

3.1.2.20 Child Health and Disability Prevention Program Covered Services.

3.1.3 Health Education and Prevention. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima Health's health education referral line for classes provided to Members.

3.1.4 Coordination and Continuation of Care. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services, monitoring progress of Members' care, and coordinating the utilization of services. Provider's referrals for Covered Services, including from Specialists, must follow CalOptima Policies for Authorization. All Authorizations shall be made through CalOptima's UM program. When a referral is necessary for a Member, Provider agrees to refer the Member to other Participating Providers in all circumstances except when an Authorization has been granted in advance by CalOptima to refer to a non-Participating Provider, or when necessary due to an Emergency Medical Condition. Provider shall forward the results of diagnostic procedures and consultations for Member in a timely manner to ensure that the Member's care is efficiently coordinated.

3.1.5 Health Risk Assessments. Provider must complete HRAs in accordance with requirements from Programs, Government Contracts, Laws, and CalOptima Policies.

3.1.6 Initial Health Assessments.

3.1.6.1 Provider shall have a process in place to ensure each Member is scheduled for an initial health assessment ("**IHA**") within one hundred twenty (120) days following enrollment with CalOptima, unless otherwise directed by CalOptima and/or the Member's PCP determines that the Member's medical records contains complete IHA information from the previous 12 months. At a minimum, IHAs shall be initially completed and periodically re-administrated for all Members in accordance with DHCS's Population Health Management Program Guide and CalOptima Policies and shall include:

3.1.6.1.1 Administration of the Staying Healthy Assessment Tool;

3.1.6.1.2 A medical history of the Member's physical and mental health;

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3.1.6.1.3 Weight and height data, blood pressure, and preventive health screens, services, and tests required under CalOptima Policies;

3.1.6.1.4 Assessment and discussion of appropriate preventive measures, identification or risks, and arrangement of future follow-up appointments, as indicated;

3.1.6.1.5 Health education; and

3.1.6.1.6 Diagnosis and plan for treatment of any diseases.

Provider shall perform the IHA within the primary care medical setting in a way that is culturally and linguistically appropriate for the Member and documented in the Member's medical record. The IHA shall include the identification, assessment, and development of care plans, as appropriate for Members with special health care needs.

3.1.6.2 For Members under twenty-one (21) years of age, the IHA and periodic health assessments shall comply with the following:

3.1.6.2.1 The IHA and periodic health assessments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Provider shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of the periodic health assessment. Provider shall ensure that Members are referred to appropriate Medi-Cal dental providers and provide Medically Necessary federally required adult dental services and fluoride varnish.

3.1.6.2.2 Provider shall arrange for provision of (i) all necessary immunizations to ensure that the Member is up to date for their age group, (ii) an adverse childhood experiences screening, and (iii) any other DHCS-required age-specific screenings, including developmental screenings.

3.1.6.2.3 Where a request is made for preventive services within the first one hundred twenty (120) days of enrollment, Provider must schedule the appointment for the Member to have a visit within ten (10) Business Days of the Member's request, unless Member declines a visit within ten (10) Business Days of the request and chooses another appointment date.

3.1.6.2.4 eporting to CalOptima, as part of Provider's Encounter Data reporting, all preventative services provided to Members.

3.1.6.3 If the Member refuses IHA services, Provider must document that refusal in the Member's Medical Record in accordance with CalOptima Policies, indicating that IHA services were advised and the Member (if an emancipated

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minor) or the Member's parent(s) or guardians voluntarily refused such services.

3.1.6.4 CalOptima may establish minimum performance requirements for completion of the IHA. Provider's failure to perform at or in excess of minimum performance requirements shall subject Provider to sanctions in accordance with this Contract and CalOptima Policies. Provider shall ensure that IHA is recorded in the Member's Medical Record.

3.1.7 Pediatric Preventive Service Appointments. Provider shall provide periodic pediatric screenings and assessments, including for vision and hearing, in accordance with the AAP schedule and CalOptima Policies and provide according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices ("**ACIP**"). If there is a conflict in the recommendations, the higher standard will be recognized. Provider shall ensure adult Members receive periodic health assessments and recommended immunizations according to the guidelines published by the United States Preventive Services Task Force and ACIP. Vaccinations that are not part of the standard protocol for pediatrics and adults shall be administered according to CalOptima Policies. Provider shall coordinate all Pediatric Preventive Services with the Orange County CHDP Program.

3.1.8 Obstetrical Services for Medi-Cal Members. If Provider provides obstetrical services, Provider must complete the Program-specific CalOptima Pregnancy Notification Report ("**PNR**") for all pregnant Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

3.1.9 Newborn Services. Provider shall provide all Covered Services to any newborn child or children born to a Member for the month of birth and the following month under the Capitation Payment for the Member who gave birth to the child.

3.1.10 Alcohol and Substance Use Disorder Treatment Services. Provider shall provide SBIRT services to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs and refer Members to CalOptima for alcohol and substance use disorder treatment when there is a need beyond SBIRT. Provider shall document SBIRT services in Members' Medical Records.

3.1.11 Mental and Behavioral Health. Provider shall coordinate mental health and Behavioral Health Services, including Medi-Cal Specialty Mental Health Services, with other providers in accordance with CalOptima Policies, Government Contracts, Laws, and Program requirements.

3.1.12 ICT Participation. Provider shall participate with the ICT to contribute to the ICP in accordance with Program guidelines and CalOptima Policies.

3.1.13 Outpatient Mental Health Services. Provider may provide Outpatient Mental Health Services within the scope of its practice. Provider shall refer Members with mild to moderate impairment in functioning requiring mental health Covered Services beyond the scope of Provider practice to CalOptima for referral to mental health Specialists. Provider shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care to the Orange County Health Care Agency or another agency as appropriate.

3.1.14 [insert additional PCP services that are Covered Services under the Contract].

3.2 **Non-PCP Services**. Provider shall furnish Non-PCP Services to eligible Members, and those services shall be reimbursed in accordance with Section 2 of Attachment B. Excluding Emergency Services, Provider must obtain Authorization prior to providing all Non-PCP Services to qualify for reimbursement in accordance with CalOptima Policies. Provider shall also obtain Authorization from Provider to provide any Covered Services to Members that are not assigned to Provider by CalOptima.

3.3 **UM Program and Medical Necessity**. The actual provision of any Covered Services are subject to CalOptima Health's Policies and UM program and the Medical Necessity of the service. Provider shall provide assessment and evaluation services ordered by a court or legal mandate. Disputes about Medical Necessity can be appealed pursuant to CalOptima Health Policies.

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Days to Appointment**. Provider shall ensure that (i) appointments for non-Emergency Services or non-Urgent Care Services are scheduled within ten (10) Business Days for Provider and fifteen (15) Business Days for Specialist and (ii) health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) days of Member's request for an appointment. If Provider supplies maternity Covered Services, Provider shall utilize the most current standards and guidelines of the American College of Obstetricians and Gynecologists as the minimum measure of quality for perinatal services. Provider shall also have a process in place for follow-up on Member missed appointments.

4.2 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.3 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.4 **Model of Care**. Provider shall comply with the model of care specified in each Program.

4.5 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.6 **Interdisciplinary Care**. Provider shall provide all information requested by the ICT, including Medical Necessity documentation, that pertains to a Member's condition and drug therapy regimen, untoward effects, or allergic reactions.

4.7 **Prescription Drug Compliance**. Provider shall comply with CalOptima's Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List require prior Authorization by CalOptima in accordance with CalOptima Policies. Provider shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist. Provider shall obtain Authorization in accordance with CalOptima Policies and provide CalOptima with all information requested by CalOptima, including for Authorizations, Medical Necessity documentation, a

Member's condition and drug therapy regimen, and untoward effects/allergic reactions. Provider shall participate in any of CalOptima's pharmacy cost containment programs, as applicable.

4.8 **EDI Exchange**. Provider shall participate in the exchange of electronic transactions with CalOptima, including electronic claims submission (EDI), verification of eligibility and enrollment through electronic means, and submission of electronic Authorization transactions in accordance with CalOptima Policies.

4.9 **Sensitive Services Information**. If Provider supplies Sensitive Services, including Family Planning Services, Provider shall comply with Laws relating to Members' Family Planning information and records, and Provider is solely responsible for developing and implementing policies and procedures to ensure compliance with such confidentiality requirements. Provider shall not release Family Planning information and records to any third party without the prior written consent of the Member. Notwithstanding the foregoing, provider shall provide Family Planning information to CalOptima and/or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

4.10 **Referrals**.

4.10.1 SPD. Provider shall refer to CalOptima all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State that identifies the aid category under which a Member is eligible to receive Covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system.

4.10.2 WIC. Provider shall make referrals to the Women, Infants and Children Food Supplementation Program ("**WIC**") in accordance with WIC program policies and procedures.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least $1,000,000 per incident/$3,000,000 aggregate per year. CalOptima is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against CalOptima are to be waived.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.1 Commercial General Liability of $1,000,000 per incident/$2,000,000 aggregate per year.

5.2.2 Commercial Crime Liability of $250,000 aggregate per year.

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5.2.3 Automobile Liability of $500,000 combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ARTICLE 6
CALOPTIMA RESPONSIBILITIES

6.1 **Pediatric Preventive Services Notifications**. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service and CHDP screening requirements based on the schedule established by the AAP.

6.2 **Approved Drug List**. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

6.3 **Communication Channels**. CalOptima will assign a representative to serve as Provider's primary contact with CalOptima. The representative will coordinate contracting, education/training, and communication and will provide assistance related to this Contract.

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ATTACHMENT B
COMPENSATION

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws, and Provider shall accept as payment in full from CalOptima for services provided under this Contract the amounts set forth in this Attachment B.

1.1 Medically Necessary Services. This Contract does not provide incentives, nor will it be construed to provide incentives, for Providers to reduce or withhold Medically Necessary services. Provider will not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medically Necessary services. Provider will ensure the continuity of services in the event of non-payment from CalOptima in accordance with Laws and Government Contract requirements.

1.2 Due Date. If a due date provided for under this Contract is a weekend or State or federal holiday, any such report, objection, or payment will be due the following Business Day.

1.3 File Transfer. The Parties agree to deliver the confidential data utilizing a secure file transfer protocol ("**SFTP**") process. The Parties will establish a SFTP site and provide the credentials necessary to access and push files to the site.

1.4 Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to Provider yearly or quarterly based on Provider's quality performance and achievement specified program goals, as determined by CalOptima in its sole discretion. CalOptima shall not pay Provider any supplemental payments if this Contract terminates.

2. **Payment**.

2.1 Medi-Cal.

2.1.1 For Covered Services provided to Medi-Cal Members, CalOptima shall reimburse Provider for Covered Services as follows:

2.1.1.1 **Professional Services: @@Custom Field{Anc Mcal PCT Amt}@@% of the CalOptima Medi-Cal Fee Schedule**, as defined in CalOptima Policies, in effect for the date of service.

2.1.1.2 Non-Professional Services: Non-professional services shall be paid at XXX**%** of the Current Medi-Cal Fee Schedule, as defined in the CalOptima Policies, in effect for the date of service.

2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, Provider will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, Laws, and CalOptima Policies.

2.1.3 *Claims Requirements*. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims in accordance with Medi-Cal billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal Fee Schedule at the time of service are not reimbursable under this Contract.

2.1.3.1 Report Codes shall be billed and paid according to Medi-Cal rules and guidelines.

2.2 OneCare.

2.2.1 For Covered Services provided to OneCare Members, CalOptima shall reimburse Provider as follows:

2.2.1.1 **@@Custom Field{Anc McAdv PCT Amt}@@ % of the Medicare Allowable Fee Schedule** in effect for the date of service.

2.2.2 *Claims Requirements*. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules, guidelines, and payment policies. Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.4.

2.2.2.1 Report Codes shall be billed and paid according to Medicare rules and guidelines.

2.3 PACE.

2.3.1 For Covered Services provided to PACE Members, CalOptima shall reimburse Provider as follows:

2.3.2 **@@Custom Field{Anc PACE PCT Amt}@@% of the Medicare Allowable Fee Schedule** in effect for the date of service.

2.3.3 *Claims Requirements*. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medicare billing rules, guidelines, and payment policies. Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.4.

2.3.3.1 Report Codes shall be billed and paid according to Medicare rules and guidelines.

2.4 Covered California.

2.4.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.4.1.1 [INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

2.5 Services with Unestablished Fees. If a fee has not been established by Medi-Cal, when providing services to a Medi-Cal Member, or Medicare, when providing services to a OneCare or PACE Member, for a particular procedure and CalOptima has provided Authorization for Provider to provide such service, CalOptima shall reimburse Provider under the following guidelines:

2.5.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services will be paid at [Percent] of Provider's full billed charges and must follow applicable Medi-Cal and Medicare billing rules and guidelines. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Provider shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima

will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

3.8 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or PACE, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

3.9 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent.